

Industrial Commission of Arizona



Staff Proposal and Request for Public Comment

2021/2022 Arizona Physicians' and Pharmaceutical Fee Schedule

Medical Resource Office
Phone (602) 542-4308 / Fax (602) 542-4797
mro@azica.gov

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The accompanying file contains the following tables, which are referenced in this Staff Proposal:

RBRVS Fee Schedule 2021 (all codes)

Anesthesia Codes and Anesthesia Conversion Factor (00100–01999)

Surgery Codes (10021–69990)

Radiology Codes (70010–79999)

Pathology/Laboratory Codes (80047–89398)

Medicine Codes (90281–96999)

Physical Medicine Codes (97010–98969)

Special Services Codes (99000-99607 and AZ Specific Codes)

Evaluation and Management Codes (99201–99499)

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I. INTRODUCTION.

The information contained in this Staff Proposal is based on a review of various resources, including the following: (1) *CY 2021 Medicare Physician Fee Schedule* (“MPFS”), a RBRVS-based reimbursement fee schedule used by Centers of Medicare & Medicaid Services (“CMS”); (2) OPTUM 360’s 2021 publication *The Essential RBRVS*; (3) Office of Workers’ Compensation Programs (“OWCP”) Fee Schedule Effective October 1, 2020; (4) *2021 Anesthesia Base Units as listed in CPT®*, a schedule of base units used by CMS to compute allowable amounts for anesthesia services; (5) *2021 Clinical Diagnostic Laboratory Fee Schedule*, a fee schedule maintained by CMS that identifies state-specific rates for pathology and laboratory services; (6) *Physicians as Assistants at Surgery: 2020 Update*; and (7) the Myers and Stauffer 2020 White Paper, titled “Pharmaceutical Reimbursement: Review of Pricing Methodologies within Workers’ Compensation.”

This document includes the methodology for setting reimbursement values of new codes and existing codes for Anesthesia, Surgery, Radiology, Pathology/Laboratory, Medicine, Physical Medicine and Rehabilitation, Special Services, Evaluation and Management, and Category III.

This Staff Proposal is preliminary and intended to serve as a proposal for public comment and discussion during the public hearing process. Following the public hearing, staff of the Industrial Commission of Arizona (the “Commission”) will provide supplemental information to the Commission, including a summary of public comments received and staff recommendations. The Commission, at a later duly noticed public meeting, will take formal action to adopt a 2021/2022 Physicians’ and Pharmaceutical Fee Schedule (“2021/2022 Fee Schedule”).

Note: The Commission is not permitted to include descriptors associated with five-digit CPT® codes in its Fee Schedule.

II. PROPOSALS AND REQUEST FOR PUBLIC COMMENT REGARDING THE 2021/2022 PHYSICIANS' AND PHARMACEUTICAL FEE SCHEDULE.

A. Adoption of Updates to Relative Value Units and Reimbursement Values.

Staff proposes adoption of the service codes, relative value units (“RVUs”), and reimbursement values contained in Tables 1 through 10, found in the accompanying file.

The Staff Proposal is based upon continued use of a RBRVS reimbursement system, in which reimbursement values are calculated by multiplying “resources required to perform a service or RVUs” by a dollar value conversion factor (“CF”). The proposed 2021/2022 Fee Schedule is based upon the following two-step methodology to compute reimbursement values for all applicable service codes:

STEP 1: Establishing RVUs or Anesthesia Base Units (“BUs”) for each service code. This was done using one of the five methods below:

- a. Utilize applicable RVUs from the 2021 MPFS or BUs from the *2021 Anesthesia Base Units from 2021 CPT*[®]. The 2021 MPFS was the preliminary source for assigning and updating RVUs for all service codes.
- b. Utilize applicable RVUs from OPTUM 360’s 2021 publication *The Essential RBRVS*. This method was used to assign and update RVUs for all “gap” codes not included in the 2021 MPFS.

Please note, the Commission is not permitted to publish the RVUs assigned to “gap” codes contained in the 2021 edition of *The Essential RBRVS* by OPTUM 360.

- c. Utilize applicable RVUs from OWCP’s *Fee Schedule Effective October 1, 2020*. This method was used to assign and update RVUs for codes that could not be assigned using the first two methods.
- d. Utilize applicable RVUs from the *2021 Clinical Diagnostic Laboratory Fee Schedule*. This method was used to update RVUs for most pathology and laboratory service codes.
- e. Utilize a back-filling approach to assign RVUs for any service codes that have a current rate but could not be assigned RVUs using the above methods. This method involved backing into overall RVUs by dividing the current reimbursement value for a service code by the applicable current conversion factor.

STEP 2: Once RVUs were assigned to all service codes, reimbursement values were calculated by multiplying the applicable RVU by the appropriate Arizona-specific conversion factor. Staff proposes that the 2021/2022 Fee Schedule continue using a multiple conversion factor model, consisting of one conversion factor for Anesthesia Services, a second for

Surgery/Radiology, and a third for all remaining service categories (including E & M, Pathology and Laboratory, Physical Medicine, General Medicine, and Special Services).

The three proposed conversion factors for the 2021/2022 Fee Schedule are as follows:

RBRVS Conversion Factors	
Anesthesia	\$61.00
Surgery/Radiology	\$70.00
All Other Services	\$65.00

Note: The above-described methodology does not apply to service codes that could not be assigned an RVU using the five methods stated earlier. Service codes of this nature are identified as By Report (BR)¹, Bundled², Not Covered or RNE³.

Note: Additionally:

- a. The proposed 2021/2022 Fee Schedule continues to use CMS’s surgical global periods.
- b. The proposed 2021/2022 Fee Schedule continues to assign RVUs to consultation services, recognizing the functional importance of these services. However, these consultation service codes observe the bundling principles used by CMS to avoid excessive reimbursement rates.
- c. The proposed 2021/2022 Fee Schedule does not incorporate a geographic adjustment factor (“GAF”), but instead uses the Arizona-specific conversion factor to adjust payment for the state. CMS utilizes one GAF for the entire State of Arizona.
- d. All CPT® codes that contain explanatory language specific to Arizona will continue to be preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in CPT® are preceded by an “AZ” identifier and numbered in the following format: AZxxx.
- e. The proposed 2021/2022 Fee Schedule does not include a Stop Loss or Stop Gain cap for any service code.

¹ BY REPORT (BR) in the value column indicates that the value of the service is to be determined “by report” because the service is too unusual or variable to be assigned a reimbursement value based unit relativity. Additional information about the BR designation is contained in the Fee Schedule Introduction.

² BUNDLED in the value column indicates there are several services/supplies that are covered under Medicare and have codes, but they are services for which Medicare bundles payment into the payment for other related services. If a carrier receives a claim that is solely for a service or supply that must be mandatorily bundled, the claim for payment should be denied by the carrier.

³ RELATIVITY NOT ESTABLISHED (“RNE”) in the value column indicates new or infrequently performed services for which sufficient data has not been collected to allow establishment of a relativity. RNE items are clearly definable and not inherently variable as are BR procedures. A report may be necessary.

B. Designation of Medi-Span® as the Publication to Determine Average Wholesale Price, Wholesale Acquisition Cost, and Generic Equivalent Average Price.

Staff proposes that Medi-Span® be used to determine Average Wholesale Price (“AWP”), Wholesale Acquisition Cost (“WAC”), and Generic Equivalent Average Price (“GEAP”) in the 2021/2022 Fee Schedule.

C. Designation of the Most-Recent CMS Update as the Publication to Determine National Average Drug Acquisition Cost.

Staff proposes that the most-current CMS Update found on the official website (<https://data.medicaid.gov/Drug-Pricing-and-Payment/NADAC-National-Average-Drug-Acquisition-Cost-/a4y5-998d/data>) be used to determine National Average Drug Acquisition Cost (“NADAC”) in the 2021/2022 Fee Schedule.

D. Adoption of Deletions, Additions, General Guidelines, and Identifiers of the CPT®.

The proposed 2021/2022 Fee Schedule is based upon staff review of deletions and additions to CPT®. The proposed 2021/2022 Fee Schedule is intended to conform to changes that have taken place in the 2021 edition of CPT®.

E. Change in the Format of the Arizona-Specific Codes.

Staff proposes a modification to the format of all Arizona-specific codes. Currently, the prefix “AZ099” appears at the beginning of each Arizona-specific code. Staff proposes changing the Arizona-specific prefix to “AZ”. This prefix would be followed by three digits that are specific to each unique code. The resulting alphanumeric code is comprised of five characters (AZxxx), similar to current CPT® codes.

F. General Amendments to the Fee Schedule.

Staff proposes to update all references to the American Medical Association’s *Current Procedural Terminology* publication throughout the Fee Schedule. Specifically, the word “Physician’s” before “Current Procedural Terminology” will be removed and references to the edition will likewise be removed. The publication will be referred to as “CPT®” to avoid the need to update the Guidelines to reference the edition of the CPT® publication in effect.

Note: Proposed amendments to the Fee Schedule as described in Paragraphs II(E) – (L) of the Staff Proposal are reflected in Exhibit A, attached.

G. Amendments to the Introduction.

Staff proposes to amend the Introduction section of the Fee Schedule, as follows:

Section A(10)

Delete section A(10). Consultation services are defined by their respective billing codes in the Fee Schedule. The description and accompanying essential criteria of a consultation billing code

govern how the service may be performed and when it may be billed. Staff has encountered questions about consultation services as a result of the apparent inconsistency between section A(10) and section H. Staff believes that deleting paragraph A(10) eliminates the potential confusion.

Section A(14)

Add the following new section (A(14)) to clarify that the Fee Schedule applies to the payment of telehealth services:

Reimbursement values for telehealth services are governed by the Fee Schedule. Performance of telehealth services are governed by Arizona Revised Statutes, Title 36, Chapter 36.

Section B(13)

Add the following new section (B(13)) to provide guidance on reimbursing ambulance service providers.

The Fee Schedule does not apply to ambulance service providers. Service fees for ambulance transportation are set and mandated by the Arizona Department of Health Services through its [Arizona Ground Ambulance Service Rate Schedule](#) and [Arizona Air Ambulance Service Rate Schedule](#). A.R.S. § 36-2239(D) states “an ambulance service shall not charge, demand or collect any remuneration for any service greater or less than or different from the rate or charge determined and fixed by the [Department of Health Services] as the rate or charge for that service.” Service fees published in the Arizona Ground Ambulance Service Rate Schedule and Arizona Air Ambulance Service Rate Schedule are applicable in the workers’ compensation setting.

Section H

Change “difficult problems” to “complex cases” to clarify intent.

Section I(4)

Update the language to further clarify that a manufacturer’s invoice for materials and supplies must be dated within one year of the billed date to provide adequate documentation to justify reimbursement. The manufacturer’s invoice must accompany a request for payment.

Update the language to indicate that medications administered in a clinical setting should be billed using CPT® code 99070 and reimbursed according to the Pharmaceutical Fee Schedule Guidelines. The administration of medications by a healthcare provider are billed using separate unique CPT® codes.

Section J

Add “NADAC,” “WAC,” and “GEAP” to the list of acronyms.

H. Amendments to the Pharmaceutical Fee Schedule Guidelines.

Based in part on research and recommendations presented in the Myers and Stauffer 2020 White Paper, titled “Pharmaceutical Reimbursement: Review of Pricing Methodologies within Workers’ Compensation,” published on the MRO webpage, staff proposes to amend the Pharmaceutical Fee Schedule Guidelines, as follows:

Section II

Add definitions for “National Average Drug Acquisition Cost” or “NADAC,” “Wholesale Acquisition Cost” or “WAC,” “Generic Equivalent Average Price” or “GEAP,” and “Therapeutically-Similar” medication.” In addition, update the definitions of “Pharmacy Accessible to the General Public” and “Pharmacy Not Accessible to the General Public” to be consistent with recent legislative changes to A.R.S. § 23-908.

Section III(E)

Amend subsection III(E) to reflect the updated proposed reimbursement methodology (*see* Section III(F), below) and to incorporate the proposals described in Paragraphs II(B) & (C) of the Staff Proposal (adopting nationally-recognized pharmaceutical publications).

Section III(F)

Amend the reimbursement methodology for prescription medications, as follows:

The reimbursement value for a prescription medication shall be determined by reference to the original manufacturer’s NDC and shall be calculated on a per unit basis as follows:

1. Generic drugs:

- a. If the medication is listed in NADAC: (125% of NADAC per unit) x (number of units dispensed).
- b. If the medication manufactured by one company is not listed in NADAC and the same medication manufactured by one or more different companies is listed in NADAC: (125% of the lowest NADAC of the same medication per unit) x (number of units dispensed).
- c. If the medication is not listed in NADAC and the same medication is not manufactured by one or more companies that is listed in NADAC, the lesser of the following:
 - i. (80% of WAC per unit) x (number of units dispensed).
 - ii. (60% of AWP per unit) x (number of units dispensed).
 - iii. (60% of the GEAP per unit) x (number of units dispensed).

2. Brand name drugs:

- a. If the medication is listed in NADAC: (102% of NADAC per unit) x (number of units dispensed).
- b. If the medication is not listed in NADAC, the lesser of the following:
 - i. (100% of WAC per unit) x (number of units dispensed).
 - ii. (85% of AWP per unit) x (number of units dispensed).

Section III(H)

Add new paragraph III(H) to establish the reimbursement value for OTC medications that are “commercially available,” as follows:

The reimbursement value for OTC medications shall be calculated on a per unit basis, as of the date of dispensing, based on the retail price (per unit) of the OTC medication in settings where the medication is commercially available.

Section III(I)

Add new paragraph III(I) to establish the reimbursement value for OTC medications that are not “commercially available,” as follows:

Subject to Section III(J), the reimbursement value for OTC medications that are not commercially available in pharmacies accessible to the general public shall be calculated on a per unit basis, as of the date of dispensing, based on the retail price (per unit) of the most therapeutically-similar OTC medication commercially available in pharmacies accessible to the general public.

Section III(J)

Add new paragraph III(J) to establish the maximum reimbursement value for OTC topical creams/lotions and topical patches that are not “commercially available,” as follows:

The reimbursement value for OTC medications that are not commercially available may not exceed:

1. Thirty dollars (\$30.00) for a thirty-day supply (or a pro-rated amount if the supply is greater or less than thirty days) for a topical cream or lotion.
2. Seventy-five dollars (\$75.00) for a thirty-day supply (or a pro-rated amount if the supply is greater or less than thirty days) for topical patches.

Section VIII

Amend Section VIII to update provisions pertaining to dispensing fees, including the provision for an \$11.00 dispensing fee for generic non-compound prescription medications reimbursed based on NADAC pricing, as follows:

A. Generic Non-Compound Drugs

1. If a generic non-compound prescription medication is dispensed by a pharmacy accessible to the general public pursuant to a prescription order, a dispensing fee of up to eleven dollars (\$11.00) per prescription medication or repackaged medication may be charged if the reimbursement value is determined pursuant to Section III(F)(1)(a) or (b) (using NADAC). If a generic non-compound prescription medication is dispensed by a pharmacy accessible to the general public pursuant to a prescription order, a dispensing fee of up to seven dollars (\$7.00) per prescription medication or repackaged medication may be charged if the reimbursement value is determined pursuant to Section III(F)(1)(c) (using WAC, AWP, or GEAP). Dispensing fees do not apply to OTC medications that are not prescribed by a medical practitioner.
2. If a generic non-compound prescription medication is dispensed by a medical practitioner or in a pharmacy not accessible to the general public pursuant to Section VII(A), (B), or (C), a dispensing fee of up to eleven dollars (\$11.00) per prescription medication or repackaged medication may be charged if the reimbursement value is determined pursuant to Section III(F)(1)(a) or (b) (using NADAC). If a generic non-compound prescription medication is dispensed by a medical practitioner or in a pharmacy not accessible to the general public pursuant to Section VII(A), (B), or (C), a dispensing fee of up to seven dollars (\$7.00) per prescription medication or repackaged medication may be charged if the reimbursement value is determined pursuant to Section III(F)(1)(c) (using WAC, AWP, or GEAP). If an OTC medication is dispensed by a medical practitioner or by a pharmacy not accessible to the general public, a dispensing fee is not permitted.

B. Brand Name or Compound Drugs

1. If a brand name or compound prescription medication is dispensed by a pharmacy accessible to the general public pursuant to a prescription order, a dispensing fee of up to seven dollars (\$7.00) per prescription medication may be charged. Dispensing fees do not apply to OTC medications that are not prescribed by a medical practitioner.
2. If a brand name or compound prescription medication is dispensed by a medical practitioner or in a pharmacy not accessible to the general public pursuant to Section VII(A), (B), or (C), a dispensing fee of up to seven dollars (\$7.00) per prescription medication may be charged. If an OTC medication is dispensed by

a medical practitioner or by a pharmacy not accessible to the general public, a dispensing fee is not permitted.

- C. If a prescription or OTC medication is administered by a medical practitioner, a dispensing fee is not permitted.

I. Amendments to the Surgery Guidelines.

Staff proposes to add the following language in the Surgery Guidelines to clarify how to determine the global period when multiple procedures are performed during the same operative session:

When performing multiple procedures with different global period values during the same operative session, the global period value for the session is the largest global period value.

J. Amendments to the Radiology Guidelines.

Staff proposes to add references to “ambulatory surgery centers” in the Radiology Guidelines to clarify that the services performed in an ambulatory surgery center are managed similarly to services performed in a hospital.

K. Amendments to the Physical Medicine and Rehabilitation Guidelines.

Staff proposes to amend the Physical Medicine and Rehabilitation Guidelines section of the Fee Schedule, as follows:

Section A

Amend section A to clarify proper billing practices for initial evaluations and re-evaluations for both physical therapy and occupational therapy. Healthcare providers treating injured workers should utilize CPT[®] criteria to select the appropriate evaluation and re-evaluation codes in accordance with the Fee Schedule.

Sections B and C

The current Fee Schedule states that more than “five additional modalities or therapeutic procedures must have prior approval of the payer.” In 2020, the Commission adopted CMS standards for billing time-based services. Additionally, the Physical Medicine Guidelines indicate in Section C that “[a]pproval must be obtained by the payer prior to performing therapeutic procedures in excess of 60 minutes.”

Based on stakeholder feedback, staff proposes amending sections B and C to distinguish “modalities” from “therapeutic procedures” and to outline the quantity of each that may be performed in a single day without prior approval. As proposed, up to three modalities and four units (or 67 minutes) of therapeutic procedures may be performed in a single day without prior authorization. Furthermore, the time spent in performing modalities will not count towards the total time for performing therapeutic procedures.

Section G

Add guidance pertaining to documentation expectations for billing Physical Medicine and Rehabilitation services.

Sections A through G

Add clarifying language and examples consistent with the Medicare Claims Processing Manual, Chapter 5, Section 20.2.

L. Amendments to the Evaluation and Management Guidelines.

Finally, staff proposes to add the following language in the Evaluation and Management Guidelines to clarify that documentation and review of records is inclusive to the performance of an evaluation and management service and to clarify the manner in which a physician may bill for time that is not already accounted for in an evaluation and management service:

Documentation and review of records is inclusive to the performance of the appropriate E/M service. A healthcare provider shall only be reimbursed for time that is not accounted for in the E/M service code by billing codes 99354, 99355, 99356, 99357, 99358, or 99359. Proper documentation must justify the use of these codes and accompany the invoice.

Staff also proposes to update the Evaluation and Management Guidelines to conform to current CPT[®] guidelines related to evaluation and management services.

Exhibit A

ARIZONA PHYSICIANS' AND PHARMACEUTICAL
FEE SCHEDULE
2021/2022



Adopted by
The Industrial Commission of Arizona

Contact Medical Resource Office
Phone (602) 542-4308 / Fax (602) 542-4797
mro@azica.gov

Effective October 1, 2021 through September 30, 2022

2020/2021 ARIZONA PHYSICIANS' & PHARMACEUTICAL FEE SCHEDULE

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INTRODUCTION

Since 1925, when the Arizona Legislature passed the state's first Workers' Compensation Act ("Act"), the Industrial Commission of Arizona ("Commission") has administered the workers' compensation laws of that Act. The Act includes the authority of the Commission to set a schedule of fees to be charged by healthcare providers attending injured employees (also referred to in this document as "injured worker" or "claimant." A.R.S. § 23-908(B). In 2004, the Act was amended to include the setting of fees for prescription medicines required to treat an injured employee. A.R.S. § 23-908(C). This fee schedule is referred to as the Arizona Physicians' and Pharmaceutical Fee Schedule (Fee Schedule).

Any reference to "healthcare providers" in the Fee Schedule is intended to include all licensed professionals whose scope of practice allows them to legally provide services to injured workers. Any reference to "physician" in relation to workers' compensation cases includes the following: doctors of medicine, doctors of osteopathy, doctors of podiatric medicine, doctors of chiropractic, doctors of naturopathic medicine, certified registered nurse anesthesiologists, physician assistants and nurse practitioners. Healthcare providers treating employees under industrial coverage are entitled by law to charge according to the schedule of fees adopted by the Commission. Accurate calculation of fees based upon this schedule, the monthly filing of reports and bills for payment, and the use of forms prescribed are essential to timely and correct payment for a provider's services and can be vital in the award of benefits to the injured worker and their dependents.

This Fee Schedule has been updated to incorporate by reference the 2021 Edition of the American Medical Association's *Physicians' Current Procedural Terminology, Fourth Edition* (CPT[®]-4) [publication](#), including the general guidelines, identifiers, modifiers, and terminology changes associated with the adopted codes. In this Fee Schedule CPT[®]-4 codes that contain explanatory language specific to Arizona are preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in CPT[®]-4 are preceded by an AZ identifier and numbered in the following format: AZ0xxx-xxx. To the extent that a conflict may exist between an adopted portion of the CPT[®]-4 and a code, guideline, identifier or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control.

- a. The Commission has also adopted by reference: 1) The unit values and guidance for consultative, diagnostic and therapeutic services published in the most recent edition of *Relative Value Guide*, American Society of Anesthesiologists <https://www.asahq.org>; 2) The *1995 and 1997 Documentation Guidelines for Evaluation and Management Services*, Centers for Medicare and Medicaid Services (CMS) <https://www.cms.gov>; 3) The *2021 Clinical Diagnostic Laboratory Fee Schedule*, Centers for Medicare and Medicaid Services (CMS) Clinical Laboratory fee Schedule <https://www.cms.gov>; 4) The *National Correct Coding Initiative Edits*, CMS; <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>; 5) *2021 Optum—360 The Essential RBRVS* <https://www.optum360.com/>; and 6) *Physicians as Assistants at Surgery: 2020 Update* <https://www.facs.org/>. The RBRVS based fee schedule adopts surgical global periods published by CMS.

Except as otherwise noted, unit values assigned to the service codes listed in this document are the product of the Industrial Commission of Arizona and are not associated in any way with the American Medical Association or any other entity or organization.

A. GENERAL GUIDANCE

1. Reimbursements and billing associated with Pharmaceuticals are found in the Pharmaceutical Fee Schedule Section of this document.
2. This Fee Schedule establishes the fees that can be charged by healthcare providers for services performed for injured workers under the Arizona's workers' compensation law.
3. If a healthcare provider or insurance carrier is referring an injured worker to a medical specialist for evaluation and/or treatment, the medical specialist's diagnosis becomes the foundational diagnosis for billing purposes.
4. Routine progress and routine final reports filed by the attending healthcare provider do not ordinarily command a fee.
5. Payment will be made for only one professional visit in any one day except when the submitted report clearly demonstrates the need for the additional visit and fee.
6. Fees for hospital, office, or home visits, subsequent to the initial visit, are not to be added to coded surgical procedures performed in the same day.
7. Routine office treatment principally by injection of drugs, other than antibiotics, requires authorization by the carrier or self-insured employer for each series of 10 after the first series of 10.
8. Except in emergencies, a carrier must be given notice regarding a consultation and the consultant must provide his/her report to the carrier and the attending healthcare provider within a reasonable period of time to facilitate processing of the claim.
9. The Commission requests that carriers notify attending healthcare providers at the same time the claimant is notified that their claim is closed with or without supportive care. If a claim is approved for reopening, the carrier should also notify the attending healthcare provider of that approval.
- ~~10. An attending healthcare provider may submit a claim for consultant's fee only when such service is requested by carrier or self-insured employer.~~
10. Missed individual appointments for consultants, without prior notification, will be compensated at 50% of consultation fee.
11. No fees may be charged for services not personally rendered by the healthcare provider, unless otherwise specified.

12. The Commission will investigate an injured workers' complaint of bad faith/unfair claims processing practices, and if appropriate, impose penalties under A.R.S. § 23-930, in those circumstances where a "peer to peer" review was not conducted by a healthcare provider with appropriate skill, training, and knowledge or where the individual performing the "peer to peer" review was not licensed. The Commission will also investigate an injured workers' complaint of bad faith/unfair claims processing practice, and if appropriate, impose penalties under A.R.S. § 23-930, for a denial of treatment based on the failure of the treating doctor to participate in a "peer to peer" review, when the treating doctor has not been given reasonable time or opportunity to participate in the "peer to peer" review.
13. As authorized under A.A.C. R20-5-128, the fee for the reproduction of medical records for workers' compensation purposes shall be 25¢ per page and \$10.00 per hour per person for reasonable clerical costs associated with locating and reproducing the documents.
14. [Reimbursement values for telehealth services are governed by the Fee Schedule. Performance of telehealth services are governed by Arizona Revised Statutes, Title 36, Chapter 36.](#)

B. PAYMENT AND REVIEW OF BILLINGS

1. Under Arizona workers' compensation law, an insurance carrier, self-insured employer or their representative is not responsible for payment of a billing for medical, surgical, and hospital benefits that the insurance carrier, employer or representative received more than 24 months from the date that the medical service was rendered, or from the date on which the provider knew or should have known that the service was rendered, whichever occurs later. A subsequent billing or corrective billing does not restart the limitations period. *See* A.R.S. § 23-1062.01.
2. It is incumbent upon the insurance carrier, self-insured employer and third party processing service to inform all parties, including the Commission, regarding changes in addresses for bill processing locations.
3. Under Arizona workers' compensation law, a healthcare provider is entitled to timely payment for services rendered. An insurance carrier, self-insured employer or claims processing representative shall make a determination whether to deny or pay a medical bill on an accepted claim, in whole or in part, including the decision as to the amount to pay, within thirty days from the date the claim is accepted, if the billing is received before the date of acceptance, or within thirty days from the date of the receipt of the billing if the billing is received after the date of acceptance. All billing denials shall be based on reasonable justification. The insurance carrier, self-insured employer, or claims processing representative shall pay the approved portion of the billing within thirty days after the determination for payment is made. If the billing is not paid within the applicable time period, the insurance carrier, self-insured employer, or claims processing representative shall pay interest to the health provider on the billing at a rate

that is equal to the legal rate. Interest shall be calculated beginning on the date that the payment to the healthcare provider is due. *See* A.R.S. § 23-1062.01.

To ensure timely payment of a medical billing, a billing must contain the information required under A.R.S. § 23-1062.01. A billing must contain at least the following information: Correct demographic patient information including claim number, if known; Correct provider information, including name, address, telephone number, and federal taxpayer identification number; Appropriate medical coding with dollar amounts and units clearly stated with all descriptions and dates of services clearly printed; and Legible medical reports required for each date of service if the billing is for direct treatment of the injured worker.

4. Payment of a workers' compensation medical billing is governed by A.R.S. § 23-1062.01, which includes:
 - a. Timeframes for processing and payment of medical bills;
 - b. Criteria for billing denials;
 - c. A provision that the injured worker is not responsible for payment of any portion of a medical bill on an accepted claim or payment of any portion of a medical billing that is being disputed;
 - d. A provision that the insurance carrier or self-insured employer may establish an internal system for resolving payment disputes;
 - e. A provision that A.R.S. § 23-1062.01 does not apply to written contracts entered into between medical providers and insurance carriers and self-insured employers or their representatives that specify payment periods or contractual remedies for untimely payments; and
 - f. A provision that the Industrial Commission does not have jurisdiction over contract disputes between the parties.
5. "Reasonable justification" to deny a bill does not include that the payment/billing policies of another private or public entities (publications) do not allow it unless the publication has been adopted by reference in the Fee Schedule.
6. Excluding bundling and unbundling issues, it is not the Commission's intent to restrict an insurance carrier's, self-insured employers or third party processing service's ability to address issues not addressed by the Fee Schedule. This includes evaluating unlisted procedures, establishment of values for unlisted procedures, establishment of values for codes that are listed as "BR" or "RNE", new CPT[®] codes that have not been adopted by the Industrial Commission, or issues outside the jurisdiction of the Fee Schedule, such as hospital billings.
7. Healthcare providers shall provide legible medical documentation and reports that are sufficient for insurance carriers/self-insured employers to determine if treatment is

being directed towards injuries sustained in an industrial accident or incident. The healthcare provider shall ensure that their patients' medical files include the information required by A.R.S. § 32-1401.2. The healthcare provider is not required to provide copies of documents or reports that they did not author and that are not in their possession (i.e., Employers' First Report of Injury).

8. Treating physicians shall submit a narrative that justifies the billing of a level 4 or 5 ~~E~~ & ~~ME/M~~ service.
9. The Commission has adopted by reference the 1995 and 1997 Documentation Guidelines for Evaluation and Management Services. Medical billings shall be prepared and reviewed consistent with how these guidelines are used and interpreted by CMS. Additionally, payers are required to disclose the guideline utilized in their Explanation of Reviews (or other similar document).
10. A payer's Explanation of Review (or other similar document) shall contain sufficient information to allow the healthcare provider to determine whether the amount of payment is correct and whom to contact regarding any questions related to the payment. Information in the Explanation of Review (or other similar document) shall include the following:
 - a. The name of the injured worker;
 - b. The name of the payer and the name of the third party administrator ("TPA"), if applicable;
 - c. If applicable, the name, telephone number, and address of all entities that reviewed the medical billing on behalf of the payer;
 - d. If applicable, the name, telephone number and address of the party that has a written contract signed by the healthcare provider that allows the contracting party or other third party to access and pay rates that are different from those provided under this Fee Schedule;
 - e. The amount billed by the healthcare provider;
 - f. The amount of any reduction due to a written contract with the healthcare provider; and
 - g. The amount of payment.
11. Nothing in this Fee Schedule precludes a healthcare provider from entering into a separate contract that governs fees. In this instance, reimbursement shall be made according to the applicable contracted charge. In the absence of a separate contract that governs a healthcare provider's fees, reimbursement shall be made according to this Fee Schedule. A payer shall demonstrate that it is entitled to pay the contracted rate in the event of a dispute by providing a valid copy of the governing contract to the healthcare provider. If a payer fails to provide evidence that it is entitled to pay a

contracted rate, then the payer shall be required to make payment as provided in this Fee Schedule.

12. Billing for Pharmaceuticals is found in the Pharmaceutical Fee Schedule Section of this document.

13. The Fee Schedule does not apply to ambulance service providers. Service fees for ambulance transportation are set and mandated by the Arizona Department of Health Services through its Arizona Ground Ambulance Service Rate Schedule and Arizona Air Ambulance Service Rate Schedule. A.R.S. § 36-2239(D) states “an ambulance service shall not charge, demand or collect any remuneration for any service greater or less than or different from the rate or charge determined and fixed by the department as the rate or charge for that service.” Service fees published in the Arizona Ground Ambulance Service Rate Schedule and Arizona Air Ambulance Service Rate Schedule are applicable in the workers’ compensation setting.

C. REIMBURSEMENT OF MID-LEVEL PROVIDERS

1. Certified Registered Nurse Anesthetists (“CRNA’s”) are reimbursed at 85% of the fee schedule.
2. Physician Assistants and Nurse Practitioners are reimbursed at 85% of the fee schedule *except* if services are provided “incident to” a physician’s professional services. In that instance, reimbursement is required to be at 100% of the fee schedule. The following criteria are identified as establishing the “incident to” exception:
 - a. The Physician Assistant and Nurse Practitioner must work under the direct supervision of an appropriately licensed physician,
 - b. The Physician must initially see that patient and establish a plan of care for that patient (“treatment plan”),
 - c. Subsequent service provided by the Physician Assistant and Nurse Practitioner must be a part of the documented treatment plan, and
 - d. The Physician must always be involved in the patient’s treatment plan and see the patient often enough to demonstrate that the Physician is actively participating in and managing the patient’s care.
3. For purposes of the Fee Schedule, the Commission recognizes that direct supervision of a Physician Assistant or Nurse Practitioner by a Physician can be accomplished through the use modern technology and telecommunications (telemedicine) and may not require the on-site presence of the Physician when the Physician Assistant or Nurse Practitioner sees the patient. In all instances, however, and regardless of the extent to which telemedicine is used, the Physician must actively participate in and manage the patient’s care if services provided by a Physician Assistant or Nurse Practitioner are billed at 100% of the fee schedule under the “incident to” exception.

4. It is the responsibility of the Physician to document if the services provided by a Physician Assistant and Nurse Practitioner are “incident to” the Physician’s professional service. If either the incident to criteria is not met, or the documentation submitted fails to support the “incident to” criteria, the reimbursement should be made at 85% of the fee schedule.

D. DIRECTED CARE AND USE OF NETWORKS

The Arizona Workers’ Compensation Act only permits private self-insured employers to direct medical care. A.R.S. § 23-1070(A); See also *Southwest Gas Corp. v. Industrial Commission of Arizona*, 200 Ariz. 292, 25 P.3d 1164 (2001). This limitation on the scope of directed care means that employees of private self-insured employers do not have an unrestricted right to choose their own medical providers, while employees of all other employers do (including public self-insured employers).¹ Notwithstanding an employee’s right to choose, many workers’ compensation insurance carriers (“carriers”) and public self-insured employers (“employers”) have taken advantage of “networks” to reduce their costs. This is done by either creating their own network of “preferred providers” or by contracting with a third party to access private health-care networks.

Actions or conduct that impair or limit the right of an employee to choose their medical provider may rise to the level of bad faith and/or unfair claims processing practices under A.R.S. § 23-930. The Commission will investigate a complaint of bad faith/unfair claims processing practices, and if appropriate, impose penalties under A.R.S. § 23-930, in those circumstances where a carrier, employer, or TPA has engaged in conduct that results in directing a claimant to a “network” provider. The following are examples of conduct that the Commission would consider appropriate for investigation under A.R.S. § 23-930.

- A claimant is told that they must see a healthcare provider that is “in the network;”
- A claimant is told that care from a “non-network” healthcare provider is not authorized;
- A “network” healthcare provider is told that referrals are required to be made to another “network” healthcare provider;
- A “network” healthcare provider is told that they may not recommend a “non-network” healthcare provider to a patient;
- A “non-network” healthcare provider is told that care will only be authorized if provided by a “network” provider; and

¹ It should be noted that the law governing directed care is not limited to “medical doctors,” but instead applies to medical, surgical, and hospital benefits. See A.R.S. § 23-1070. The phrase, “medical, surgical, and hospital benefits” is defined in A.R.S. § 23-1062(A), which states: “Promptly, upon notice to the employer, every injured employee shall receive medical, surgical and hospital benefits or other treatment, nursing, medicine, surgical supplies, crutches and other apparatus, including artificial members, reasonable required at the time of the injury, and during the period of disability. Such benefits shall be termed ‘medical, surgical and hospital benefits.’”

- A “non-network” healthcare provider is told that reimbursement will be made according to “network” discounts.

E. TREATMENT OF INDUSTRIAL INJURIES AND DISEASES

1. Only physicians and surgeons licensed in the State of Arizona are permitted to treat injured or disabled employees under the jurisdiction of the Commission, unless others are specifically authorized.
2. An employee who sustains an injury arising out of, or in the course of, employment is entitled, under Arizona law, to select a healthcare provider of his/her own choice unless that employee is employed by a private self-insured employer as described in A.R.S. § 23-1070. Employers described in A.R.S. § 23-1070, excluding the State or Political Subdivisions thereof, are allowed to direct medical care.
3. The attending healthcare provider’s promptness and professional exactness in the completion and filing of workers’ compensation forms are extremely important to the employee being treated. The injured or disabled employee’s claim to medical benefits and compensation can rest on the conscientious attention of the healthcare provider in processing the required reports. Rules addressing the completion of these forms are found in the Title 20, Chapter 5, Article 1 of the Arizona Administrative Code, which can be obtained at: http://apps.azsos.gov/public_services/Title_20/20-05.pdf
4. The Commission, the employer and the insurance carrier may, at any time, designate a healthcare provider or healthcare providers to examine an employee. Additionally, upon application of the employer, employee, or insurance carrier, the Commission may order a change of healthcare provider or a change of conditions of treatment when there are reasonable grounds or a belief that the employee’s health or progress can thus be improved.
5. A claimant may not change doctors without the written authorization of the insurance carrier, the Commission or the attending physician. A claimant may not transfer from one hospital to another without the written authorization of the insurance carrier or the Commission. If the patient’s employment requires leaving the locale in which he/she is receiving treatment, the attending physician should arrange for continued treatment and notify the carrier of such arrangement. It is the responsibility of the physician or the hospital to which a patient has transferred to ascertain whether such a change has been authorized.
6. Treatment of conditions unrelated to the injuries sustained in the industrial accident may be denied as unauthorized if the treatment seems directed principally toward the non-industrial condition or if the treatment does not seem necessary for the patient’s physical rehabilitation from the industrial injury.
7. If the patient refuses to submit to medical examination or to cooperate with the healthcare provider’s treatments, the carrier or self-insured employer should be notified.
8. If an employee is capable of some form of gainful employment, it is proper for the healthcare provider to release the employee to light work and make a specific report to the

carrier or self-insured employer as to the date of such release. It can be to the employee's economic advantage to be released to light work, since he/she can receive compensation based on 66 2/3% of the difference between one's earnings and one's established wage. On the other hand, it would not be to the employee's economic advantage to be released to light work if, in fact, the employee is not capable of performing such work. The healthcare provider's judgment in such matters is extremely important.

9. If the employee no longer requires active medical care for the industrial injury and is discharged from treatment, the healthcare provider is required to provide a signed report with the date of discharge to the carrier or self-insured employer, even if, as a private patient, the employee may require further medical care for conditions unrelated to the industrial accident. This final report and discharge date are necessary for closing the claim file.
10. When a healthcare provider discharges a claimant from treatment, the healthcare provider shall determine whether the employee has suffered any impairment of function, or disfigurement about the head or face, including injury to or loss of teeth, and include this information in the final signed report provided to the carrier or self-insured employer. The Rules of Procedure Before the Industrial Commission of Arizona require that any rating of the percentage of functional impairment should be made in accordance with the standards of evaluation published in the most recent edition of the American Medical Association Guides to the Evaluation of Permanent Impairment.
11. Once an exposure to blood-borne pathogen occurs, the workers' compensation insurance carrier/self-insured employer is responsible for payment of the accepted treatment protocol which includes the HBIG vaccination (Hepatitis B Immune Globulin), and, if necessary, the three (3) Hepatitis B vaccinations.

When a work-related incident occurs that may have exposed an employee to Hepatitis, the insurance carrier/self-insured employer is responsible for paying for the testing and/or treatment of Hepatitis B or C. As to treatment of HIV, if a bona fide claim exists under A.R.S. § 23-1043.02, then the insurance carrier/self-insured employer is responsible for paying for the treatment.

12. It is the employer's responsibility, in accordance with existing OSHA standards, to pay for HIV testing. The insurance carrier may seek reimbursement from the employer for the costs associated with providing the series of three (3) Hepatitis B vaccinations if the employer failed to provide them in violation of federal and state laws.

F. REOPENING OF CLAIMS

1. Whether or not the employee has suffered a permanent disability, on a claim that has been previously accepted, the claim may be reopened on the basis of a new, additional or previously undiscovered disability or condition, but:
 - a. The claimant should use the form of petition prescribed by the Commission;

- b. The petition must be personally signed by the worker or his authorized representative and must be filed at any office of the Industrial Commission of Arizona;
 - c. The petition, in order to be considered, must be accompanied by the healthcare provider's medical report.
2. If the claim is reopened, the payment for such reasonable and necessary medical, hospital and laboratory work expenses shall be paid by the insurance carrier if such expenses are incurred within 15 days of the filing of the petition to reopen.
 3. No monetary compensation is payable for any period prior to the date of filing of the petition to reopen. Surgical benefits are not payable for any period prior to the date of filing of a petition to reopen, except that surgical benefits are payable for a period prior to the date of filing not to exceed seven (7) days if a bona fide medical emergency precludes the employee from filing a petition to reopen prior to the surgery. Other information relative to reopening rights may be found at A.R.S. § 23-1061(H).
 4. If a claim is approved for reopening, the carrier must notify the attending healthcare provider of that approval.

G. NO-INSURANCE CLAIMS

“No-Insurance” claims are workers’ compensation claims involving injuries to employees of employers who do not have workers’ compensation insurance coverage as required by Arizona law. In such cases, all claims and reports are to be addressed to the No-Insurance Section of the Special Fund of The Industrial Commission of Arizona.

H. CONSULTATIONS

Workers’ compensation cases can present additional medical and legal problems that justify consultation sooner and more frequently than for the average private patient. In difficult problems complex cases and in cases requiring an estimate of general or unscheduled disability, consultation with specialists in the appropriate field may be requested by any interested party. The Industrial Commission continues to recognize the necessity for consultations in workers’ compensation and establishes relative value units and rates for consultation codes.

I. DEFINITIONS OF SELECT UNIT VALUES

1. BY REPORT “BR” ITEMS: “BR” in the value column indicates that the value of this service is to be determined “by report”, because the service is too unusual or variable to be assigned a unit relativity. Pertinent information concerning the nature, intent and need for the procedure or service, the time, the skill and equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary.
2. RELATIVITY NOT ESTABLISHED “RNE” ITEMS: “RNE” in the value column indicates new or infrequently performed services for which sufficient data has not been

collected to allow establishment of a relativity. “RNE” items are clearly definable and not inherently variable as are BR procedures. A report may be necessary.

3. SERVICE “SV” ITEMS: “SV” in the value column indicates the value is to be calculated as the sum of the various services rendered (e.g., office, home, nursing home or hospital visits, consultation or detention, etc.), according to the ground rules covering those services. Identify by using the code number of the “SV” item. The Value is established by identifying each individual service, listing the code number and its value.
4. MATERIALS AND SUPPLIES: A healthcare provider is not entitled to be reimbursed for supplies and materials normally necessary to perform the service. A healthcare provider may charge for other supplies and materials using code 99070². A healthcare provider may use an applicable HCPCS code in lieu of code 99070 if the HCPCS code more accurately describes the materials and supplies provided by the healthcare provider; however, the Commission has **not** adopted the RVUs for HCPCS codes. Examples of those items that are and are not reimbursable are listed below. Documentation showing actual costs (i.e., manufacturer’s invoice ~~dated within one year of the billed date~~) associated with providing supplies and materials plus fifteen percent (15%) to cover overhead costs will be and is adequate justification for payment only when the documentation is dated within one year of the billed date. This provision does not apply to retail operations involving drugs or supplies. Drugs that are Administration of drugs administered to patients in a clinical setting is are covered under code 99070 and reimbursed according to the Pharmaceutical Fee Schedule Guidelines. Prescription drugs provided to patients as a part of the overall treatment regimen but outside of the clinical setting are not included under this code.

Examples of supplies that are usually not separately reimbursable include:

- Applied hot or cold packs
- Eye patches, injections or debridement trays
- Steristrips
- Needles
- Syringes
- Eye/ear trays
- Drapes
- Sterile gloves
- Applied eye wash or eye drops
- Creams (massage)
- Fluorescein
- Ultrasound pads and gel
- Tissues
- Urine collection kits
- Gauze
- Cotton balls/fluff
- Sterile water

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Band-Aids and dressings for simple wound occlusion
Head sheets
Aspiration trays
Sterile trays for laceration repair and more complex surgeries
Tape for dressings

Examples of material and supplies that are generally reimbursable include:

Cast and strapping materials
Applied dressings beyond simple wound occlusion
Taping supplies for sprains
Iontophoresis electrodes
Reusable patient specific electrodes
Dispensed items, including:
Canes
Braces
Slings
Ace wraps
TENS electrodes
Crutches
Splints
Back support
Dressings
Hot or cold packs

5. “Modifiers: A two-digit (numeric or alpha) sequence that provides the means by which the reporting healthcare provider can specify that a procedure performed has been altered under a procedure performed has been altered under a special circumstance. This allows defining the modifying circumstance of the service or procedure without creating a separate procedure or listing.

Modifier Examples

Professional Component (PC): Certain procedures are a combination of a physician, or Professional component and a technical component. When modifier “-26” is added to an Appropriate code a PC allowable amount will be paid.

Technical Component (TC): The TC component reflects the technical portion of the procedure code. When the technical component is provided by a healthcare provider other than the one providing the professional component, the healthcare provider bills for the technical component by adding Modifier “-TC” to the applicable code.

J. LIST OF ACRONYMS

AMA	American Medical Association
AS	Assistant Surgeon
AWP	Average Wholesale Price

BR	By Report
CCI	Current Coding Initiative (National)
CF	Conversion Factor
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetist
DME	Durable Medical Equipment
E/M	Evaluation and management services
FCE	Functional Capacity Evaluation
FUD	Follow-up day(s)
GEAP	Generic Equivalent Average Price
HCPCS	Healthcare Common Procedure Coding System
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
IME	Independent medical examination
MPFS	Medicare physician fee schedule
MRI	Magnetic resonance imaging
NADAC	National Average Drug Acquisition
NCCI	(see CCI)
NP	Nurse practitioner
OTC	Over-the-counter
PA	Physician assistant
RBRVS	Resource based relative value scale
RVU	Relative value unit
WAC	Wholesale Acquisition Cost

PHARMACEUTICAL FEE SCHEDULE

I. GENERAL PROVISIONS AND APPLICABILITY OF THE PHARMACEUTICAL FEE SCHEDULE.

- A. The Pharmaceutical Fee Schedule (PFS) applies to prescription and over-the-counter (OTC) medications required to treat an injured employee, whether dispensed by a pharmacy (including online or mail order pharmacies) or by a medical practitioner.
- B. Medications are not reimbursable unless “reasonably required” at the time of injury or during the period of disability. *See* A.R.S. § 23-1062(A); A.A.C. R20-5-1303(A). The Industrial Commission of Arizona has adopted the Official Disability Guidelines (ODG), including ODG’s Drug Formulary Appendix A (ODG Formulary), as the standard reference for evidence-based medicine used in treating injured employees within the context of Arizona’s workers’ compensation system. Effective October 1, 2018, ODG applies to all body parts and conditions. *See* A.A.C. R20-5-1301(B), (E). ODG is to be used as a tool to support clinical decision making and quality health care delivery to injured employees. The ODG Formulary sets forth pharmaceutical guidelines that are generally considered reasonable and are presumed correct if the guidelines provide recommendations related to a particular medication. *See* A.A.C. R20-5-1301(H). Medical practitioners are encouraged to consult the ODG Formulary before dispensing or prescribing medications to injured employees.
- C. Generic drugs must be dispensed to injured employees when appropriate, consistent with A.R.S. § 32-1963.01(A),¹ (B), and (D) through (L).² *See* A.R.S. § 23-908(C). For purposes of this subsection, the definitions in A.R.S. § 32-1963.01(L) apply.³ As a cost reducing measure, medical practitioners should prescribe less costly drugs whenever possible.

II. DEFINITIONS.

- A. “Administer” has the meaning set forth in A.R.S. 32-1901(1).

¹ A.R.S. § 32-1963.01(A) states: “If a medical practitioner prescribes a brand name drug and does not indicate an intent to prevent substitution as prescribed in subsection E of this section, a pharmacist may fill the prescription with a generic equivalent drug.”

² A.R.S. § 32-1963.01(E) states: “A prescription generated in this state must be dispensed as written only if the prescriber writes or clearly displays ‘DAW’, ‘dispense as written’, ‘do not substitute’ or ‘medically necessary’ or any statement by the prescriber that clearly indicates an intent to prevent substitution on the face of the prescription form. A prescription from out of state or from agencies of the United States government must be dispensed as written only if the prescriber writes or clearly displays ‘do not substitute’, ‘dispense as written’ or ‘medically necessary’ or any statement by the prescriber that clearly indicates an intent to prevent substitution on the face of the prescription form.”

³ A.R.S. § 32-1963.01(L) states, in part:

2. “Brand name drug” means a drug with a proprietary name assigned to it by the manufacturer or distributor.
* * * *
4. “Generic equivalent” or “generically equivalent” means a drug that has an identical amount of the same active chemical ingredients in the same dosage form, that meets applicable standards of strength, quality and purity according to the United States pharmacopeia or other nationally recognized compendium and that, if administered in the same amounts, will provide comparable therapeutic effects. Generic equivalent or generically equivalent does not include a drug that is listed by the United States food and drug administration as having unresolved bioequivalence concerns according to the administration’s most recent publication of approved drug products with therapeutic equivalence evaluations.

- B. “Average Wholesale Price” or “AWP” means the wholesale price charged on a specific commodity that is assigned by the drug manufacturer and is listed in a nationally-recognized drug pricing file.
- C. “Commercially available” means a drug product is widely available for purchase in pharmacies accessible to the general public, including in brick and mortar pharmacies accessible to the general public.
- D. “Compound medication” means a pharmaceutical product created by virtue of mixing or combining drugs and/or components to meet the unique needs of an individual patient when the finished product does not recreate a commercially-available product.
- E. “Dispense” or “dispensing” means to deliver to an ultimate user by or pursuant to the lawful order of a medical practitioner, including the prescribing, administering, packaging, labeling, or compounding necessary to prepare for that delivery. *See* A.R.S. § 32-1901(27).
- F. “Drug” has the meaning set forth in A.R.S. § 32-1901(31).
- G. “Generic Equivalent Average Price” or “GEAP” means a generic price applied to drug products sharing the same generic product packaging code.
- H. “Hospital” means any institution for the care and treatment of the sick and injured that is approved and licensed as a hospital by: (1) the Arizona Department of Health Services; or (2) an equivalent regulatory agency in another U.S. state, territory, or district. *See* A.R.S. § 32-1901(42).
- I. “Medical practitioner” means any person who is permitted/licensed and authorized by law to use and prescribe prescription medications, acting within the scope of such authority, for the treatment of sick and injured human beings or for the diagnosis or prevention of sickness in human beings in the State of Arizona or any U.S. state, territory or district. *See* A.R.S. § 32-1901(53).
- J. “National Average Drug Acquisition Cost” or “NADAC” means the national drug pricing benchmark developed and maintained by the Centers for Medicare & Medicaid Services (CMS), which is established and updated monthly based on invoice surveys of retail community pharmacies, available at <https://data.medicare.gov/Drug-Pricing-and-Payment/NADAC-National-Average-Drug-Acquisition-Cost-/a4y5-998d/data>.
- K. “Non-traditional strength” medication means a finished drug product in a strength (*i.e.* dosage) that is not commercially available in pharmacies accessible to the general public.
- L. “Over-the-counter medication” or “OTC medication” means a finished drug product, including label and container according to context, which does not require a prescription order.
- M. “Pharmacy” has the meaning set forth in A.R.S. § 32-1901(71).

N. “Pharmacy accessible to the general public” means a pharmacy that is readily accessible and provides pharmaceutical services (including prescription medication services) to all segments of the general public without restricting services to a defined or exclusive group of consumers, including but not limited to consumers who have access to services because they are treated by or have an affiliation with a specific entity or medical practitioner. This definition includes mail order pharmacies delivering pharmaceutical services to workers’ compensation claimants if both of the following apply:

1. The pharmacy does not limit or restrict access to claimants with an affiliation to a medical provider or other entity.
2. Any medical provider or other entity referring a claimant to the pharmacy does not receive or accept any rebate, refund, commission, preference, or other consideration as compensation for the referral.

O. “Pharmacy not accessible to the general public” means a pharmacy that provides pharmaceutical services (including prescription medication services) only to a defined or exclusive group of consumers, including but not limited to consumers who have access to services because they are treated by or have an affiliation with a specific entity or medical practitioner. “Pharmacy not accessible to the general public” does not include a hospital pharmacy. This definition does not include mail order pharmacies delivering pharmaceutical services to workers’ compensation claimants if both of the following apply:

1. The pharmacy does not limit or restrict access to claimants with an affiliation to a medical provider or other entity.
2. Any medical provider or other entity referring a claimant to the pharmacy does not receive or accept any rebate, refund, commission, preference, or other consideration as compensation for the referral.

P. “Prescription” means either a prescription order or a prescription medication. *See* A.R.S. § 32-1901(80).

Q. “Prescription medication” means any drug, including label and container according to context, which is dispensed pursuant to a prescription order. *See* A.R.S. § 32-1901(81).

R. “Prescription order” shall have the meaning set forth in A.R.S. § 32-1901(84).

S. “Repackaged medication” means a finished drug product removed from the container in which it was distributed by the original manufacturer and placed into a different container without further manipulation of the drug. The term also includes the act of placing the contents of multiple containers of the same finished drug product into one container. The term also includes “co-pack drug” products which contain two or more separate finished medications that are contained in a single package or unit. The term does not include a drug that is manipulated in any other way, including if the drug is reconstituted, diluted, mixed, or combined with another ingredient.

- T. “Traditional strength” medication means a finished drug product in a formulation that is commercially available in pharmacies accessible to the general public.
- U. “Therapeutically-similar” medication means a medication that is expected to produce a clinical effect comparable to the original product. Key considerations for determining the “most therapeutically-similar” medications are: (1) the similarity of the clinical effects; (2) the extent to which active ingredients overlap; (3) the similarity of the dosage profiles; (4) the similarity of the mode of administration; and (5) the similarity of the intended strength.
- V. “Ultimate user” means a person who lawfully possesses a prescription medication for that person's own use or for the use of a member of that person's household. *See* A.R.S. § 32-1901(95).
- W. “Wholesale Acquisition Cost” or “WAC” means the manufacturer’s list price for drugs sold to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug pricing data.

III. GENERAL GUIDELINES FOR BILLING AND REIMBURSEMENT OF PRESCRIPTION MEDICATIONS.

- A. Except as permitted in Sections VI and VII of the current PFS, an insurance carrier, self-insured employer, or the Special Fund of the Commission is responsible for the payment of prescription medications only if all of the following apply:
1. The prescription medication is dispensed by an individual who is currently licensed to practice the profession of pharmacy by either: (i) the Arizona State Board of Pharmacy; or (ii) an equivalent regulatory agency in another U.S. state, territory, or district; and
 2. The prescription medication is dispensed by a pharmacy accessible to the general public, including online or mail-order pharmacies that are accessible to the general public.
- B. Subject to Sections III(G), IV, V, and VI(B), reimbursement for prescription medications shall be based on the actual medication dispensed, including a substituted medication that is dispensed pursuant to A.R.S. § 32-1963.01.
- C. Except as specified in Sections IV and V of the current PFS, a pharmaceutical bill submitted for a prescription medication must include the National Drug Code (NDC) of the original manufacturer registered with the U.S. Food & Drug Administration (FDA), the quantity dispensed, and the reimbursement value of the medication. Under no circumstance shall an NDC other than the original manufacturer’s NDC be used.
- D. The reimbursement value for prescription medications shall be based on the current PFS reimbursement methodology in the absence of a contractual agreement between the pharmacy or medical practitioner and payer governing reimbursement. Network discounts

may not be applied in the absence of a contractual agreement with the pharmacy or medical practitioner authorizing such discounts.

- E. ~~The reimbursement value for a prescription medication shall be based on a discount from the applicable AWP, as determined by reference to the original manufacturer's NDC. The reimbursement value of a prescription medication~~ AWP shall be determined on the date a drug is dispensed from pricing published in the most recent issue, as updated in the most-recent update, of ~~a~~ nationally-recognized pharmaceutical publications designated by the Commission. For purposes of determining NADAC, the Commission has selected the most-recent update on the CMS website, available at <https://data.medicaid.gov/Drug-Pricing-and-Payment/NADAC-National-Average-Drug-Acquisition-Cost-/a4y5-998d/data>. For purposes of determining WAC, AWP, and GEAP, the Commission has selected Medi-span[®].
- F. The reimbursement value for a prescription medication shall be determined by reference to the original manufacturer's NDC and shall be calculated on a per unit basis ~~based on the applicable AWP per unit and the following methodology~~ as follows:

1. Generic drugs:

- a. If the medication is listed in NADAC: (125% of NADAC per unit) x (number of units dispensed).
- b. If the medication manufactured by one company is not listed in NADAC and the same medication manufactured by one or more different companies is listed in NADAC: (125% of the lowest NADAC of the same medication per unit) x (number of units dispensed).
- c. If the medication is not listed in NADAC and the same medication is not manufactured by one or more companies that is listed in NADAC, the lesser of the following:
- i. (80% of WAC per unit) x (number of units dispensed).
- ii. (8560% of AWP per unit) x (number of units dispensed).
- iii. (60% of the GEAP per unit) x (number of units dispensed).

2. Brand name drugs:

- a. If the medication is listed in NADAC: (102% of NADAC per unit) x (number of units dispensed).
- b. If the medication is not listed in NADAC, the lesser of the following:
- i. (100% of WAC per unit) x (number of units dispensed).
- ii. (85% of AWP per unit) x (number of units dispensed).

G. Reimbursement for non-traditional strength prescription medications shall be calculated on a per unit basis, as of the date of dispensing, based on the original manufacturer's NDC and corresponding [AWP-reimbursement methodology](#) of the most therapeutically-similar traditional strength form of the same medication. Under no circumstance shall the NDC of the non-traditional strength medication be used.

H. The reimbursement value for OTC medications shall be calculated on a per unit basis, as of the date of dispensing, based on the retail price (per unit) of the OTC medication in settings where the medication is commercially available.

I. Subject to Section III(J), the reimbursement value for OTC medications that are not commercially available in pharmacies accessible to the general public shall be calculated on a per unit basis, as of the date of dispensing, based on the retail price (per unit) of the most therapeutically-similar OTC medication commercially available in pharmacies accessible to the general public.

J. The reimbursement value for OTC medications that are not commercially available may not exceed:

1. Thirty dollars (\$30.00) for a thirty-day supply (or a pro-rated amount if the supply is greater or less than thirty days) for a topical cream or lotion.

2. Seventy-five dollars (\$75.00) for a thirty-day supply (or a pro-rated amount if the supply is greater or less than thirty days) for topical patches.

IV. BILLING AND REIMBURSEMENT FOR REPACKAGED MEDICATIONS.

A. A pharmaceutical bill submitted for a repackaged medication must identify the NDC of the repackaged medication, the NDC of the original manufacturer registered with the U.S. FDA, the quantity dispensed, and the reimbursement value of the repackaged medication. Under no circumstances shall the reimbursement value of a repackaged medication be based upon an NDC other than the original manufacturer's NDC. A repackaged NDC shall not be used for calculating the reimbursement value of a repackaged medication and shall not be considered the original manufacturer's NDC.

B. If a pharmaceutical bill for a repackaged medication is submitted without the original manufacturer's NDC, the payer has the discretion to determine the appropriate NDC (and corresponding [reimbursement value](#)^{AWP}) to use or, alternatively, may deny coverage until the appropriate NDC is furnished.

C. The reimbursement value for a repackaged medication shall be based on the current PFS reimbursement methodology contained in Section III of the PFS, utilizing the NDC(s) and corresponding [NADAC\(s\), WAC\(s\), GEAP\(s\), or AWP\(s\)](#) of the original manufacturer(s).

D. Any component of a co-pack drug product for which there is no NDC shall not be reimbursed.

V. BILLING AND REIMBURSEMENT FOR COMPOUND MEDICATIONS.

- A. A pharmaceutical bill submitted for a compound medication must identify each reimbursable component ingredient, the applicable NDC of each reimbursable component ingredient, the corresponding quantity of each component ingredient, and the calculated reimbursement value of each component ingredient. All component ingredients of a compound medication must be billed on a single bill.
- B. The reimbursement value for a compound medication shall be calculated at the component ingredient level. The reimbursement value for a compound medication shall be based on the sum of the reimbursement values of each component ingredient and the corresponding component ingredient's NDC, based on the current PFS reimbursement methodology set forth in Section III.
- C. Any component ingredient in a compound medication for which there is no NDC shall not be reimbursed.
- D. Any component ingredient in a topical compound medication that is not FDA approved for topical use shall not be reimbursed.
- E. If any component ingredient in a compound medication is a repackaged medication, the reimbursement value for the repackaged medication ingredient shall be determined based on the current PFS reimbursement methodology set forth in Section III, using the [NADAC](#), [WAC](#), [GEAP](#), or AWP corresponding to the NDC of the original manufacturer. *See* Section IV.
- F. The maximum reimbursement value for a topical compound medication shall be the lesser of:
 - 1. ~~(1)~~ ~~Two hundred dollars~~ (\$200.00) for a thirty-day supply (or a pro-rated amount if the supply is greater or less than thirty days);⁵ or
 - 2. ~~(2)~~ The reimbursement value of the compound medication calculated under this section.

VI. BILLING AND REIMBURSEMENT FOR MEDICATIONS ADMINISTERED BY A MEDICAL PRACTITIONER.

- A. A pharmaceutical bill submitted for a medication administered by a medical practitioner must comply with billing procedures outlined in Sections III, IV, and V of the current PFS, as applicable.
- B. The reimbursement value for a medication administered by a medical practitioner shall be based on the current PFS reimbursement methodology contained in Sections III, IV, and V of the PFS, as applicable.

VII. REIMBURSEMENT FOR MEDICATIONS DISPENSED BY A MEDICAL PRACTITIONER OR IN A PHARMACY NOT ACCESSIBLE TO THE GENERAL PUBLIC.^{4,5}

- A. An insurance carrier, self-insured employer, or the Special Fund of the Commission is responsible for the payment of prescription medications that are dispensed by a medical practitioner or in a pharmacy not accessible to the general public if all of the following apply:
1. The prescription medication is dispensed by a medical practitioner or a pharmacy not accessible to the general public to the injured employee within seven days of the date of the industrial injury;
 2. The prescription medication is limited to no more than a one-time, ten-day supply;
 3. The prescription medication conforms to dosages and formulations that are commercially available in pharmacies accessible to the general public.
- B. An insurance carrier, self-insured employer, or the Special Fund of the Commission is responsible for the payment of prescription medications that are dispensed by a medical practitioner or in a pharmacy not accessible to the general public if all of the following apply:
1. The injured employee does not have access to a pharmacy accessible to the general public within 20 miles of the injured employee's home address, work address, or the address of the prescribing medical practitioner;
 2. The injured employee cannot reasonably acquire the prescription medication from an online or mail order pharmacy accessible to the general public; and
 3. The prescription medication conforms to dosages and formulations which are commercially available in pharmacies accessible to the general public.
- C. An insurance carrier, self-insured employer, or the Special Fund of the Commission is responsible for the payment of prescription medications that are dispensed by a medical practitioner or in a pharmacy not accessible to the general public if the dispensing of a prescription medication for an individual claim and specified duration has been preapproved in writing by the insurance carrier, self-insured employer, or the Special Fund of the Commission. Nothing in this section requires an insurance carrier, self-insured employer, or the Special Fund of the Commission to preapprove the dispensing of prescription medications under this subsection.

⁴ Dispensing pursuant to Section VII is subject to the Arizona Opioid Epidemic Act, which imposes statutory limits on the prescribing and dispensing of schedule II opioids. For more information about the Arizona Opioid Epidemic Act, please see the FAQs published by the Arizona State Board of Pharmacy, available at <https://drive.google.com/file/d/1JCI8VwtdJ1T-DyGfJN3WWUm4KhDMXe-/view>.

⁵ Section VII sets forth reimbursement guidelines for medications dispensed in settings that are not accessible to the general public in Arizona's worker's compensation system and does not interfere with a medical practitioner's ability to dispense medications pursuant to A.R.S. § 32-1491 or seek payment from sources unrelated to workers' compensation.

- D. An insurance carrier, self-insured employer, or the Special Fund of the Commission is responsible for the payment of prescription medications that are dispensed by a pharmacy not accessible to the general public if all of the following apply:
1. The prescription medication was dispensed to an injured employee whose workers' compensation claim was initially denied by the carrier, self-insured employer, or the Special Fund of the Commission;
 2. The injured employee protested the claim denial by filing a timely request for hearing;
 3. The workers' compensation claim was either: (a) subsequently accepted by the carrier, self-insured employer, or the Special Fund of the Commission; or (b) the claim was found to be compensable by the Commission's Administrative Law Judge Division, the Arizona Court of Appeals, or the Arizona Supreme Court;
 4. The prescription medication was dispensed during the time period between: (a) the initial claim denial and (b) the subsequent acceptance of the claim or the compensability determination by the Commission's Administrative Law Judge Division, the Arizona Court of Appeals, or the Arizona Supreme Court; and
 5. The prescription medication conforms to dosages and formulations that are commercially available in pharmacies accessible to the general public.
- E. The guidelines in Section III(A) and this section do not apply to prescription medications dispensed during in-patient hospital care or upon discharge from in-patient hospital care.
- F. The reimbursement value for OTC medications dispensed by a medical practitioner or in a pharmacy not accessible to the general public shall be *calculated* on a per unit basis, as of the date of dispensing, based on the retail price (per unit) of the OTC medication in settings where the medication is commercially available.
- G. The reimbursement value for OTC medications that are dispensed by a medical practitioner or in a pharmacy not accessible to the general public and that are not commercially available in pharmacies accessible to the general public shall be calculated on a per unit basis, as of the date of dispensing, based on the retail price (per unit) of the most therapeutically-similar OTC medication commercially available in pharmacies accessible to the general public. Under no circumstance shall the NDC, ~~or AWP~~, [or other pricing methodology](#) of the non-commercially available OTC medication be used.
- H. Subject to the limitations in this section, medications that have been provided as free samples to a medical practitioner may be dispensed to an injured employee when appropriate, but are not reimbursable.

VIII. DISPENSING FEE.

- A. [Generic Non-Compound Drugs](#)

1. If a generic non-compound prescription medication is dispensed by a pharmacy accessible to the general public pursuant to a prescription order, a dispensing fee of up to eleven dollars (\$11.00) per prescription medication or repackaged medication may be charged if the reimbursement value is determined pursuant to Section III(F)(1)(a) or (b) (using NADAC). ~~seven dollars (\$7.00) per prescription medication, repackaged medication, or compound medication may be charged.~~ If a generic non-compound prescription medication is dispensed by a pharmacy accessible to the general public pursuant to a prescription order, a dispensing fee of up to seven dollars (\$7.00) per prescription medication or repackaged medication may be charged if the reimbursement value is determined pursuant to Section III(F)(1)(c) (using WAC, AWP, or GEAP). ~~The d~~Dispensing fees does not apply to OTC medications that are not prescribed by a medical practitioner.
2. If a generic non-compound prescription medication is dispensed by a medical practitioner or in a pharmacy not accessible to the general public pursuant to Section VII(A), (B), or (C), a dispensing fee of up to eleven dollars (\$11.00) per prescription medication or repackaged medication may be charged if the reimbursement value is determined pursuant to Section III(F)(1)(a) or (b) (using NADAC). If a generic non-compound prescription medication is dispensed by a medical practitioner or in a pharmacy not accessible to the general public pursuant to Section VII(A), (B), or (C), a dispensing fee of up to seven dollars (\$7.00) per prescription medication or repackaged medication may be charged if the reimbursement value is determined pursuant to Section III(F)(1)(c) (using WAC, AWP, or GEAP). ~~seven dollars (\$7.00) per prescription medication, repackaged medication, or compound medication may be charged.~~ If an OTC medication is dispensed by a medical practitioner or by a pharmacy not accessible to the general public, a dispensing fee is not permitted.

B. Brand Name or Compound Drugs

1. If a brand name or compound prescription medication is dispensed by a pharmacy accessible to the general public pursuant to a prescription order, a dispensing fee of up to seven dollars (\$7.00) per prescription medication, ~~repackaged medication, or compound medication~~ may be charged. ~~The d~~Dispensing fees does not apply to OTC medications that are not prescribed by a medical practitioner.
2. If a brand name or compound prescription medication is dispensed by a medical practitioner or in a pharmacy not accessible to the general public pursuant to Section VII(A), (B), or (C), a dispensing fee of up to seven dollars (\$7.00) per prescription medication, ~~repackaged medication, or compound medication~~ may be charged. If an OTC medication is dispensed by a medical practitioner or by a pharmacy not accessible to the general public, a dispensing fee is not permitted.

- C. If a prescription or OTC medication is administered by a medical practitioner, a dispensing fee is not permitted.

IX. ADDITIONAL BILLING GUIDELINES.

A. Paper billing by a medical practitioner:

The following is an example of how to report both the repackaged NDC and original NDC on the CMS 1500 form using the shaded area of line 24. The information is reported in the following order: qualifier (N4), NDC code, one space, unit/basis of measurement qualifier, quantity, one space, ORIG, qualifier (N4), NDC code.”

24. A.	DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OF UNITS	H. PKTS/Per	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
	From MM	DD	YY	To MM	DD	YY			CPT/HCPCS	MODIFIER								
	N4	55289047590	UN30	ORIGN4	00025152531			J3490				A	500	00	30	N	G2	12345678901
	10	01	05	10	01	05	11									N	NP	0123456789

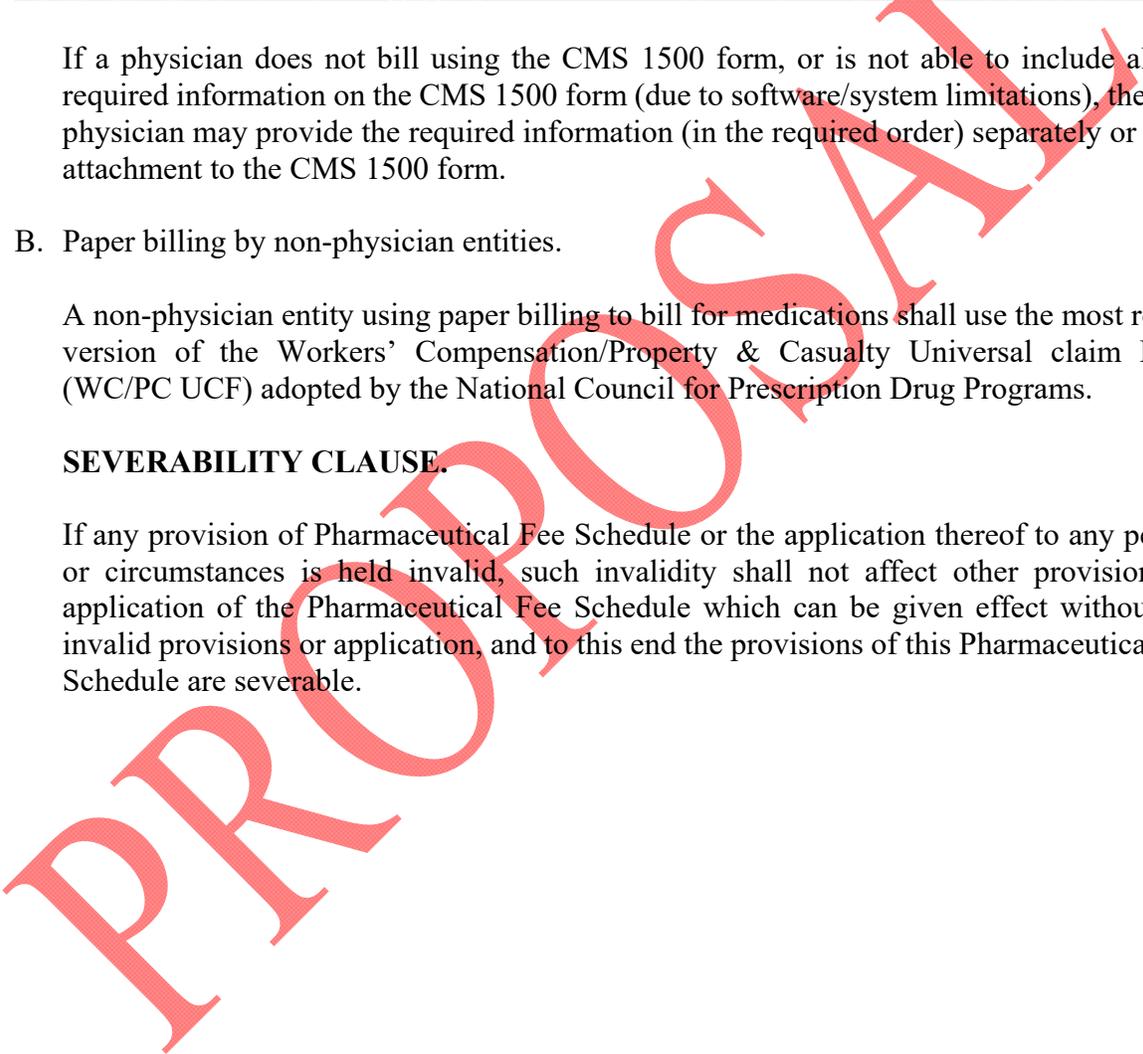
If a physician does not bill using the CMS 1500 form, or is not able to include all the required information on the CMS 1500 form (due to software/system limitations), then the physician may provide the required information (in the required order) separately or as an attachment to the CMS 1500 form.

B. Paper billing by non-physician entities.

A non-physician entity using paper billing to bill for medications shall use the most recent version of the Workers’ Compensation/Property & Casualty Universal claim Form (WC/PC UCF) adopted by the National Council for Prescription Drug Programs.

X. SEVERABILITY CLAUSE.

If any provision of Pharmaceutical Fee Schedule or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or application of the Pharmaceutical Fee Schedule which can be given effect without the invalid provisions or application, and to this end the provisions of this Pharmaceutical Fee Schedule are severable.



SURGERY GUIDELINES

This Fee Schedule has been updated to incorporate by reference the 2021 Editions of the American Medical Association's *Physicians' Current Procedural Terminology*, ~~Fourth Edition~~ (CPT[®]-4) publication, including the general guidelines, identifiers, modifiers, and terminology changes associated with the adopted codes. In this Fee Schedule CPT[®] codes that contain explanatory language specific to Arizona are preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in CPT[®]-4 are preceded by an AZ identifier and numbered in the following format: AZ0xxx-xxx.

The Commission has also adopted by reference: 1) The *1995 and 1997 Documentation Guidelines for Evaluation and Management Services*, Centers for Medicare and Medicaid Services (CMS) <https://www.cms.gov>; 2) *2021 Optum 360 The Essential RBRVS* <https://www.optum360.com/>; 3) The *National Correct Coding Initiative Edits*, CMS <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>; and, 4) *Physicians as Assistants at Surgery Update 2020* <https://www.facs.org>. The RBRVS-based fee schedule adopts surgical global periods published by CMS. Additional information regarding publications adopted by reference is found in the Introduction of the Fee Schedule.

The following Commission guidelines are in addition to the CPT[®] guidelines and represent additional guidance from the Commission relative to unit values for surgical services. To the extent that a conflict may exist between CMS, an adopted portion of the CPT[®]-4 and a code, guideline, identifier or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control.

- A. **MATERIALS AND SUPPLIES:** A healthcare provider may charge for materials and supplies as described in subsection (I)-(4) of the Introduction Section of the Physician's Fee Schedule (pages 11-12).
- B. **MULTIPLE PROCEDURES:** It is appropriate to designate multiple procedures that are rendered on the same date by separate entries. However, the primary procedure code is the code that determines the follow-up days when a surgery has multiple procedures. The additional procedure(s) or service(s) may be identified by appending modifier -51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes.
- C. **SPECIAL REPORT:** A typical request for more detailed information from an insurance carrier regarding a billing does not constitute a "special report", which is defined in the CPT[®] book.
- D. **MODIFIERS:** Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of the appropriate modifier code, which may be reported in either of two ways. The modifier may be reported by a two-digit number placed after the usual procedure number from which it is separated by a hyphen. Or the modifier may be reported by a

separate five-digit code that is used in addition to the procedure code. If more than one modifier is used, the “Multiple Modifiers” code placed first after the procedure code indicates that one or more additional modifier codes will follow.

Modifiers either unique to Arizona or containing explanatory language specific to Arizona are as follows:

Δ-22 Increased Procedural Services: Use of this modifier will result in a twenty-five percent (25%) increase in the listed value for the listed procedure.

Δ-25 Separately Identifiable Evaluation and Management Service by same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service. It may be necessary to indicate that on the day a procedure or service identified by a CPT® code was performed, the patient’s condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). As such, different diagnoses are not required for reporting of the E/M services on the same date. The circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.

Δ-47 Anesthesia by Surgeon: The value shall be fifty percent (50%) of the calculated American Society of Anesthesiologists Relative Value Guide value.

Δ-50 Bilateral Procedure: Unless otherwise identified in the listings, when bilateral procedures which add significant time or complexity to patient care are provided at the same operative session, identify and value the first or major procedure as listed. Identify the secondary or lesser procedure(s) by adding this modifier ‘-50’ to the usual procedure number(s) and value at fifty percent (50%) of the listed value(s). If, however, the procedures are independently complex and involve different parts of the body, including digits, the bilateral procedure rule would not apply. In such cases, independent procedures would be billed at one hundred percent (100%) of their listed value.

Δ-51 Multiple Procedures: When multiple procedures are performed during the same operative session*, the procedures should be valued at the appropriate percent of its listed value, as shown below:

100% (full value) for the first or major procedure

50% for the second and multiple procedure(s)

Sixth and subsequent procedures – by report

*Multiple Procedure Guidelines do not apply to codes specifically identified as “Add-on/Additional Procedures, Global indicator ZZZ”.

The major or primary procedure is defined as the procedure with the highest value and is the code that determines the follow-up days when a surgery has multiple procedures. The second

procedure is the procedure with the next highest value, the third the next highest value, and so on.*** If, however, the procedures are independently complex such as digits, tendons, nerves or artery repair, the multiple procedure rule would not apply. In such cases, independent procedures would be billed at one hundred percent (100%) of their listed value.

When performing multiple procedures with different global period values during the same operative session, the global period value for the session is the largest global period value.

Δ-57 Decision for Surgery: An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

Δ-62 Two Surgeons: By prior agreement, the total value of services performed by two surgeons working together as primary surgeons may be apportioned in relation to the responsibility and work done, provided the patient is made aware of the fee distribution according to medical ethics. If no apportionment listed, the fee should be split evenly between the co-surgeons. The total value may be increased by twenty-five percent (25%) in lieu of the usual assistant's charge. Under these circumstances the services of each surgeon should be identified by adding this modifier '-62' to the joint procedure number(s) and valued as agreed upon. (Usual charges for surgical assistance may be warranted if still another physician is required as part of the surgical team.) The value of the procedure should be 125 percent of the customary value listed. Payment of 125% of the maximum allowable would be divided between the participating surgeons.

Two Surgeons – When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on codes(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s)) are performed during the same surgical session, separate code(s) may be reported with modifier -62 added. **Note:** If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

Δ-80 Assistant Surgeons: These services are valued at twenty percent (20%) of the listed value of the surgical procedure(s).

– OR –

Δ-81 Minimum Assistant Surgeons: These services are valued at ten percent (10%) of the listed value of the surgical procedure(s).

RADIOLOGY GUIDELINES

This Fee Schedule has been updated to incorporate by reference the 2021 Edition of the American Medical Association's *Physicians' Current Procedural Terminology, Fourth Edition* (CPT®-4) [publication](#), including the general guidelines, identifiers, modifiers, and terminology changes associated with the adopted codes. In this Fee Schedule CPT® codes that contain explanatory language specific to Arizona are preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in CPT®-4 are preceded by an AZ identifier and numbered in the following format: AZ0xxx-xxx. Additional information regarding publications (e.g. CMS Guidelines) adopted by reference is found in the Introduction of the Fee Schedule.

The following Commission guidelines are in addition to CMS and CPT® guidelines, and represent additional guidance from the Commission relative to unit values for these services. To the extent that a conflict may exist between an adopted portion of the CPT®-4 and a code, guideline, identifier or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control.

A. GENERAL GUIDELINES

1. Values include usual contrast media, equipment and materials. An additional charge may be warranted when special surgical trays and materials are provided by the healthcare provider.
2. Values include consultation and written reports to the referring healthcare provider.
3. X-ray findings and attending healthcare provider's written order for x-rays must be included with statement for x-ray services. Bills unsupported by findings will not be paid.
4. X-rays should be taken, reported, and be properly marked for identification and orientation in accordance with the accepted standard of radiologic practice in the State of Arizona.

B. MODIFIERS

Modifiers identify circumstances that alter or enhance the description of the service. For radiology codes, two modifiers affect the assigned unit value and are listed in *The Essential RBRVS*. However, other modifiers may be required for correct reporting of service. See CMS and the 2021 CPT®-4 publications for additional information on modifiers. Listed radiology modifiers affect the unit values as follows:

1. Total: When no modifier is listed, the unit value represents the global value of the procedure. The five-digit code is used to represent a global service inclusive of professional and technical value of providing that service. The following sections, provide additional definitions for each component.

2. Professional: Modifier 26 is used to designate professional services. The professional component includes examination of the patient, when indicated, performance and/or supervision of the procedure, interpretation and written report of the examination, and consultation with referring healthcare providers.
3. Technical: Modifier TC is used to designate the technical value of providing the service. The technical component includes personnel, materials, space, equipment, and other allocated facility overhead normally included in providing the service. Note that modifier TC is not CPT® compatible.

C. REFERENCE TO RELATIVE VALUES

Two patterns of billing currently prevail in radiology. A total charge for the radiology service, to include both professional fees and technical costs, is made by radiologists working in offices, clinics and, under some circumstances, in hospital or ambulatory surgery center x-ray departments.

In a majority of voluntary hospital or ambulatory surgery center radiology departments, the radiologist submits a separate statement to the patient for his professional services. The hospital or ambulatory surgery center charges for use of the department facilities and the services of its employees. This pattern is similar to the charges made by the hospital or ambulatory surgery center for the use of delivery rooms or surgical suites. Such charges are entirely separate from the fees charged by obstetricians and surgeons. In most separate radiology billing situations, the total will approximate the amount billed singly by the radiologist in their office or billed singly by the hospital or ambulatory surgery center.

The two separate scales in Radiology Relative Values have been devised for use in radiology and are not coordinated with scales for services in other branches of medicine such as surgery, medicine or pathology. The two scales are compatible only within themselves. Within each of the two separate headings, the total dollar value and the PC or professional components dollar value, where appropriate, can be used. Some procedures are noted as a “BR” value or “By Report”. This usage is intended to indicate that circumstances involving a given patient procedure may require much more than the average amount of time and effort to perform and thus a value would be unique and could not be anticipated or established. When such added involvement is claimed, a written explanation will usually be required as an addendum to the bill.

The PC values do not include charges made by the hospital in which the procedure was accomplished. Such charges by the hospital or ambulatory surgery center cover the services of technologists and other helpers, the films, contrast media, radioactive agents, chemical and other materials, the use of the space and facilities of the x-ray department plus any other hospital or ambulatory surgery center costs. Most hospitals or ambulatory surgery centers have derived their own schedule of charges of these items. ~~The e~~Establishment of ~~the hospital's~~ or ambulatory surgery center charges is not ~~properly~~ the subject of ~~this publication~~ the Fee Schedule.

The separation of billing in no way implies a division of responsibility, but only a division of the charge. The radiologist is a physician performing a needed medical service for a patient, and he must retain full responsibility for his own activity and also full responsibility for the supervision of technologists, the selection and maintenance of equipment, the control of radiation hazards and the general administration of the radiology department.

D. REVIEW OF DIAGNOSTIC STUDIES

No separate charge is warranted for prior studies reviewed in conjunction with a visit, consultation, record review, or other evaluation by a healthcare provider; neither the professional component value modifier 26 nor the radiological consultation CPT® code 76140 is reimbursable. The review of diagnostic tests is included in the evaluation and management codes.

PROPOSAL

PHYSICAL MEDICINE AND REHABILITATION GUIDELINES

This Fee Schedule has been updated to incorporate by reference the 2021 Edition of the American Medical Association's *Physicians' Current Procedural Terminology, Fourth Edition* (CPT®-4) publication, including the general guidelines, identifiers, modifiers, and terminology changes associated with the adopted codes. In this Fee Schedule CPT® codes that contain explanatory language specific to Arizona are preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in CPT®-4 are preceded by an AZ identifier and numbered in the following format: AZ0xxx-xxx. Additional information regarding publications adopted by reference is found in the Introduction of the Fee Schedule.

The following Commission guidelines are in addition to the CPT® guidelines and represent additional guidance from the Commission relative to physical medicine and rehabilitation unit values for these services. To the extent that a conflict may exist between an adopted portion of the CPT®-4 and a code, guideline, identifier or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control.

General requirements in reporting services are found in the Introduction of the Fee Schedule. In addition to the definitions and commonalities preceding the coded medical procedures, several other requirements unique to this Section ~~on (Physical Medicine and Rehabilitation)~~ PHYSICAL MEDICINE are defined or identified as follows:

- A. Physical therapy (PT) evaluation codes (97161-97163) and occupational therapy (OT) evaluation codes (97165-97167) are billed at the initial visit and a re-evaluation code (97164 for PT, 97168 for OT) may be billed During the course of physical medicine treatments, only one evaluation and management billing is allowed per week, except that the following evaluations are allowed once every two calendar weeks following an initial evaluation: 97164, 97168, and 97172. Additional billing for PT and OT evaluation and management procedures evaluation services may be allowed when specific additional services are warranted. Approval of the payer must be obtained prior to performing additional services. Criteria to select the appropriate evaluation and re-evaluation codes are outlined in the current CPT® publication.

~~NOTE: IT IS IMPORTANT TO NOTE THAT THESE LIMITATIONS DO NOT APPLY TO REFERRING HEALTHCARE PROVIDERS OR TO HEALTHCARE PROVIDERS WHO TREAT PATIENTS ONCE PER MONTH.~~ These limitations do not apply to referring healthcare providers or to providers who treat patients once per month.

- B. When multiple modalities (untimed 97010*2 through 9703928, time based 97032-97036) are performed, the first modality (or the first unit of a time-based modality) is reported as listed. The second modality (or the second unit of a time-based modality) is identified by adding modifier “-51” to the code number. The second and each subsequent modality (or unit(s) of a time-based modality) should be valued at 50% of its listed value.

First modality reported or first unit of a time-based modality -100% ~~Full value for the first modality~~
Second, third, and additional approved modality or unit(s) - 50% ~~For the second and additional modalities~~

~~*97010 is bundled in the payment when a separate Physical Therapy Service is performed.~~

Any more than ~~5-three additional~~ modalities or more than three units of a time-based modality per body part being treated ~~or therapeutic procedures~~ must have prior approval of the payer. The time a healthcare provider bills for a time-based modality (97032-97036) does not count towards the total timed therapeutic procedure maximum of four units or 67 minutes.

NOTE: 97010 is a bundled service and not separately reportable.

Example:

During a visit a patient receives the following ~~care~~ services:

45 minutes therapeutic exercise (97110) ~~for 45 minutes,~~

15 minutes mechanical traction (97012) ~~for 15 minutes,~~

15 minutes unattended electrical stimulation (97014) ~~for 15 minutes and~~

10 minutes ultrasound 97035

15 minutes moist heat (97010) ~~for 15 minutes~~ while receiving the electric stimulation

Under the multiple ~~procedure modality~~ rule, the healthcare provider would bill:

97110 3 units at 100% of value (therapeutic procedure, timed code)

97012 1 unit at 100% of value (untimed code)

97014 1 unit at 50% of value (untimed code)

97035 1 unit at 50% of value (timed code)

97010 is bundled into the above services and not paid as a separate service

~~you would bill 100% of the total value for (97110) therapeutic exercise (\$56.23 x 3), 100% of the total value for (97012) mechanical traction (\$27.79 x 1) and 50% of the total value for (97014) electrical stimulation (\$26.50 x 50%) and 0% (zero percent) for moist heat (97010), for a total billing of \$209.73. Moist heat (97010) is paid at 0% (zero percent) because it is bundled with the physical therapy service (therapeutic exercise, 97110).~~

- C. CPT® Ccodes describing therapeutic procedures (97110-97150 and 97530-97546) are not subject to the multiple ~~procedure modality~~ rule and shall be paid at 100% of their listed value. When performing therapeutic procedure(s); (excluding work hardening/conditioning, (97545-97546), and physical test or measures for Ffunctional Ccapacity Eevaluation, 97750), a maximum of four units or 670 minutes is allowed each day. Approval must be obtained by the payer prior to performing therapeutic procedures in excess of 60 minutes this maximum (e.g., when multiple body parts are treated in a single visit).

- D. The values for the codes in this section ~~apply to~~ include the time and work of the provider, s time, expertise and use of the equipment required to provide the service, and the cost of the healthcare provider's liability insurance. Medications and disposable electrodes used in these procedures should be considered supplies, code 99070, (see ~~item Section A 1,~~ in the Guidelines for Medicine Section Guidelines and Subsection (I)(4) of the Fee Schedule Introduction regarding billing for supplies).
- E. Time-Based Physical Medicine and Rehabilitation Services CPT® codes are billed according to guidance ~~provided by~~ from the Centers for Medicare and Medicaid Services (CMS), as published in the Medicare Claims Processing Manual, Chapter 5, Section 20.2, C. Counting Minutes for Timed Codes in 15 Minute Units.

When only one service is provided in a day, healthcare providers should not bill for services ~~performed~~ provided for less than 8 minutes. For any single 15-minute timed CPT code ~~service provided in a~~ the same day measured in 15-minute units, healthcare providers bill a single 15-minute unit for treatment of greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single procedure in a day is greater than or equal to 23 minutes through and including 37 minutes, two units should be billed. Please refer to the ~~following table below,~~ which outlines the billing units for each time interval how to bill for up to four units or 67 minutes, without payer approval.

Units	Number of Minutes
0	< 8 minutes
1	≥ 8 minutes and ≤ 22 minutes
2	≥ 23 minutes and ≤ 37 minutes
3	≥ 38 minutes and ≤ 52 minutes
4	≥ 53 minutes and ≤ 67 minutes

If additional therapeutic procedures are approved by the payer, the pattern for determining time/units is continued.

When more than one service represented by 15-minute timed codes is performed in a single day, the total number of minutes of service (~~as noted in the chart above~~) determines the number of timed units billed (as noted in the chart above). ~~If~~ For any service represented by a 15-minute timed service code that is performed for 7 minutes or less on the same day as another service also represented by a 15-minute timed service code ~~that was also~~ performed for 7 minutes or less, and the total time of these two services is 8 minutes or greater, ~~then~~ the provider may bill one unit ~~for the of~~ service that was performed for the most minutes. The same logic is applied ~~if when~~ if three or more different services are ~~provided~~ performed on the same day for 7 minutes or less, ~~than 7 minutes. See example below.~~

~~During a visit, a patient receives the following care: therapeutic exercise (97110) for 45 minutes, manual therapy (97140) for 5 minutes, and therapeutic activities (97530) for 7 minutes. The provider would bill 3 units of therapeutic exercise (97110) and 1 unit of therapeutic activities (97530). Since the total time spent on therapeutic activities and~~

~~manual therapy is greater than 8 minutes (7 minutes + 5 minutes = 12 minutes), one unit should be billed. The unit billed is for therapeutic activities (97530) since the time spent on that time-based service is greater than the time spent on manual therapy (97140).~~

The expectation, ~~(based on the work values assigned for to these codes),~~ is that a provider's direct patient contact time for each unit will average 15 minutes in length. If more than one 15-minute timed CPT® code is billed during a single calendar day, the total number of units billed is constrained by the total treatment time for that day. ~~The healthcare provider is also expected to include the duration (in minutes) for each time-based service in their documentation.~~

When documenting to support the billing of timed CPT® codes, the provider should document the total number of timed minutes and the total time of the treatment provided that day. Total treatment time includes the minutes for timed code treatment and untimed code treatment. Total treatment time does not include time for services that are not billable (e.g., rest periods). The amount of time for each specific intervention/modality provided to the patient is not required to be documented in the treatment note.

It is important that the total number of timed treatment minutes support the billing of units on the invoice and that the total treatment time also reflects the services billed as untimed codes. The billing and the total timed code treatment minutes documented must be consistent. Additional guidance for documentation of timed codes is found in the CMS Benefit Policy Manual, Chapter 15, 220.3, E. Treatment Note

Examples on how to count the appropriate number of minutes for the total therapy minutes provided:

Example 1

During a visit, the patient receives the following services:

45 minutes therapeutic exercise 97110

5 minutes manual therapy 97140

7 minutes therapeutic activities 97530

Total Timed Codes – 57 minutes

The healthcare provider would bill: 4 units

97110 3 units

97530 1 unit

Since the total time spent providing manual therapy and therapeutic exercises is greater than 8 minutes, one unit is billed of the service which was performed for more time.

Example 2

During a visit, the patient receives the following services:

24 minutes neuromuscular reeducation 97112

23 minutes therapeutic exercise 97110
Total Timed Codes: 47 minutes

The healthcare provider would bill: 3 units

97112 2 units

97110 1 unit

Each service is provided for more than 15 minutes, so at least one unit is appropriate for each. Two units are billed for Neuromuscular reeducation since that service was performed for more time.

Example 3

During a visit, the patient receives the following services:

20 minutes therapeutic activities 97530

20 minutes therapeutic exercise 97110

Total Timed Codes: 40 minutes

The healthcare provider would bill: 3 units

97530 2 units

97110 1 unit

OR

97110 2 units

97530 1 unit

Each service was provided for 20 minutes, which would allow for one unit for each service. However, the total time of 40 minutes allows for three units to be billed. Since the time for each service is the same, the provider can choose which code to bill for two units and which code to bill for one unit.

Example 4

During a visit, the patient receives the following services:

33 minutes therapeutic exercise 97110

7 minutes manual therapy 97140

Total Timed Codes: 40 minutes

The healthcare provider would bill: 3 units

97110 2 units

97140 1 unit

The first 30 minutes of therapeutic exercise is 2 units. The remaining 3 minutes is added to the 7 minutes of manual therapy and then is billed for one unit of manual therapy. The time for manual therapy is greater than the remaining time from the therapeutic exercise.

Example 5

During a visit, the patient receives the following services:

18 minutes therapeutic exercise 97110

13 minutes manual therapy 97140

10 minutes gait training 97116

8 minutes ultrasound 97035

Total Timed Codes: 49 minutes

The healthcare provider would bill: 3 units

97110 1 unit

97140 1 unit

97116 1 unit

Bill the procedures that the most time was spent performing. One unit each of 97110, 97140, and 97116. Although the ultrasound should be documented, it cannot be billed, as the healthcare provider is constrained by the total timed codes minutes. Since the total timed codes is 49 minutes, only three units would be billed.

- F. A work hardening program is limited to 6 1/2 hours per day, not to exceed a 6 week period of time.
- G. The payer has the right to require documentation to establish that a modality or therapeutic procedure was performed. Inasmuch as these Guidelines allow for re-evaluations to be performed every two weeks, it is at that time the healthcare provider should ~~be required to address and document the success status of the treatment protocol, i.e. improvements or lack of improvements regarding stamina, flexibility and strength.~~

It is not appropriate for the payer on a per billing basis to require a healthcare provider to provide unnecessary detailed documentation to justify payment. A healthcare provider is required to comply with A.R.S. § 23-1062.01 when submitting a bill. For example, the purpose of modalities like hot and cold packs, paraffin baths, and whirlpools are straightforward. Modalities are utilized as a sub-element of the over-all treatment protocol to prepare the injured worker for therapy or to minimize the impact of the therapy on the injured worker. Other than a statement that certain modalities were performed, any additional documentation such as the purpose of the application of modalities, resulting flexibility or comfort is unnecessary. Additionally, listing the amount of weight an individual is lifting, repetitions, and sets is, again, unnecessary. During a re-evaluation visit, the healthcare provider should provide documentation regarding changes in strength, stamina, and flexibility.

Documentation of each treatment shall include the following elements:

- Date of treatment.
- Identification of each specific intervention/modality provided and billed, both timed and untimed services in a manner that it can be compared with the billing record to verify correct coding.

- Total timed code treatment minutes and total treatment time in minutes (the amount of time for each specific intervention/modality provided is not required).
- Signatures (written or electronic) and professional designation of the qualified healthcare provider who furnished or supervised the services provided.

PROPOSAL

EVALUATION AND MANAGEMENT GUIDELINES

This Fee Schedule has been updated to incorporate by reference the 2021 Edition of the American Medical Association's *Physicians' Current Procedural Terminology, Fourth Edition* (CPT[®]-4) [publication](#), including the general guidelines, identifiers, modifiers, and terminology changes associated with the adopted codes. In this Fee Schedule CPT[®] codes that contain explanatory language specific to Arizona are preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in CPT[®]-4 are preceded by an AZ identifier and numbered in the following format: AZ0_xxx-xxx. Additional information regarding publications adopted by reference is found in the Introduction of the Fee Schedule.

The evaluation and management guidelines adopted by reference may be found in the *Current Procedural Terminology[®], Fourth Edition* ("CPT[®]-book") published by the AMA and is reprinted, in part, below with permission. To the extent that a conflict may exist between an adopted portion of the CPT[®]-4 and a code, guideline, identifier or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control.

Documentation and review of records is inclusive to the performance of the appropriate E/M service. A healthcare provider shall only be reimbursed for time that is not accounted for in the E/M service code by billing codes 99354, 99355, 99356, 99357, 99358, or 99359. Proper documentation must justify the use of these codes and accompany the invoice.

~~On March 26, 2020 the Commission approved the adopted two HCPCS codes used for a Virtual check-in with physicians via a number of communication technology modalities including synchronous discussion over a telephone or exchange of information through video or image. Virtual check-ins are initiated by the patient and may be performed via multiple technology modalities including telephone, secure text messaging, email, or use of a patient portal. The two HCPCS codes are included in the 2021/2022 Fee Schedule:~~

G2010 – Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.

G2012 – Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.

A. CLASSIFICATION OF EVALUATION AND MANAGEMENT (E/M) SERVICES:

The E/M section is divided into broad categories such as office visits, hospital visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital visits (initial and

subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes. ~~This classification is important because the nature of work varies by type of service, place of service, and the patient's status.~~

The basic format of the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, e.g., office consultation. Third, the content of the service is defined, ~~e.g. comprehensive history and comprehensive examination. (See "Levels of E/M Services" in 2020 AMA CPT® codebook, for details on the content of E/M services).~~ Fourth, ~~the nature of the presenting problem(s) usually associated with a given level is described.~~ time is specified. A detailed discussion of time is provided in Section C ~~(Fifth, the time typically required to provide the service is specified.~~

B. DEFINITIONS OF COMMONLY USED TERMS:

Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting by physicians ~~in differing specialties. E/M services may also be reported by other qualified health care professionals who are authorized to perform such services within the scope of their practice.~~ The definitions in the E/M Guidelines are provided solely for the basis of code selection.

Some definitions are common to all categories of services and others are specific to one or more categories only.

C. GUIDELINES COMMON TO ALL E/M SERVICES.

- Levels of E/M Services: Within each category or subcategory of E/M service, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are NOT interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient. Each level of E/M services may be used by all physicians.
- **New and Established Patient:** Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by physicians who may report evaluation and management services reported by a specific CPT® code(s). A new patient is one who has not received any professional services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

In the instance where a physician is on call for or covering for another physician, the patient's encounter will be classified as it would have been by the physician who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialties as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

- Time: The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions of the CPT® codebook. The inclusion of time as an explicit factor beginning in CPT® 1992 is done to assist in selecting the most appropriate level of E/M services. Beginning with CPT® 2021, except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Different categories of services use time differently. It is important to review the instructions for each category.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult to provide accurate estimates of the time spent face-to-face with the patient.

Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service. Time may only be used for selecting the level of the *other* E/M services when counseling and/or coordination of care dominates the service.

When time is used for reporting E/M services codes, the time defines in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician. For office or other outpatient services, if the physician's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

A shared or split visit is defined as a visit in which a physician and other qualified health care professional jointly provide face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (i.e., when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate prolonged services code may be reported. The appropriate time should be documented in the medical record when it is used as the basis for code selection.

Face-to-face time (outpatient consultations [99241, 99242, 99243, 99244, 99245], domiciliary, rest home, or custodial services [99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337], home services [99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350], cognitive assessment and care plan services [99483]): For coding purposes, face-to-face time for these services is defined as only that time spent face-to-face with the patient and/or family. This includes the time spent performing such tasks as obtaining a history, examination, and counseling the patient.

Unit/floor time (hospital observation services [99218, 99219, 99220, 99224, 99225, 99226, 99234, 99235, 99236], hospital inpatient services [99221, 99222, 99223, 99231, 99232, 99233], inpatient consultations [99521, 99522, 99523, 99524, 99525], nursing facility services [99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318]): For coding purposes, time for these services is defined as unit/floor time, which includes the time present on the patient's hospital unit and at the bedside rendering services for that patient. This includes the time to establish and/or review the patient's chart, examine the patient, write notes, and communicate with other professionals and the patient's family.

Total time on the date of the encounter (office or other outpatient services [99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215]): For coding purposes, time for these services is the total time on the date of the encounter. It includes both the face-to-face and non-face-to-face time personally spent by the physician on the day of the encounter (includes time in activities that require the physician and does not include time in activities normally performed by clinical staff.

Physician time includes the following activities when performed:

- Preparing to see the patient (e.g., review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medical examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals (when not separately reported)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination (not separately reported)

Do not count time spent on the following:

- The performance of other services that are reported separately

- Travel
- Teaching that is general and not limited to discussion that is required for the management of a specific patient

~~• **Chief Complaint:** A chief complaint is a concise statement describing the symptom, problem, condition, diagnosis, or other factor that is the reason for the encounter, usually stated in the patient's words.~~

- **Concurrent Care and Transfer of Care:** Concurrent care is the provision of similar services (e.g., hospital visits) to the same patient by more than one physician on the same day. When concurrent care is provided, no special reporting is required. Transfer of care is the process whereby a physician who is providing management for some or all of a patient's problems relinquishes this responsibility to another physician who explicitly agrees to accept this responsibility and who, from the initial encounter, is not providing consultative services. The physician transferring care is then no longer providing care for these problems though he or she may continue providing care for other conditions when appropriate. Consultation codes should not be reported by the physician who has agreed to accept transfer of care before an initial evaluation but are appropriate to report if the decision to accept transfer of care cannot be made until after the initial consultation evaluation, regardless of site of service.

- **Counseling:** Counseling is a discussion with a patient and/or family concerning one or more of the following areas:

- Diagnostic results, impressions, and/or recommended diagnostic studies;
- Prognosis;
- Risks and benefits of management (treatment) options;
- Instructions for management (treatment) and/or follow-up;
- Importance of compliance with chosen management (treatment) options;
- Risk factor reduction; and
- Patient and family education.

(For psychotherapy, see 90832-90834, 90836-90840)

~~• **Family History:** A review of medical events in the patient's family that includes significant information about:~~

- ~~• The health status or cause of death of parents, siblings and children;~~
- ~~• Specific diseases related to problems identified in the Chief Complaint or History of the Present Illness, and/or System Review;~~
- ~~• Diseases of family members which may be hereditary or place the patient at risk.~~

- Services Reported Separately: Any specifically identifiable procedure or service (i.e., identified with a specific CPT code) performed on the date of E/M services may be reported separately.

The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when the professional interpretation of those tests/studies reported separately by the physician reporting the E/M service. Tests that do not require separate interpretation (e.g., tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation, but may be counted as ordered or reviewed for selecting an MDM level. Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The physician's interpretation of the results of diagnostic tests/studies (i.e., professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code, and, if required, with modifier 26 appended. If a test/study is independently interpreted in order to manage the patient as part of the E/M service, but is not separately reported, it is part of the MDM.

The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant separately identifiable E/M service. The E/M service may be caused or prompted by the symptoms or conditions for which the procedure and/or service was provided. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. As such, different diagnoses are not required for reporting of the procedure and the E/M services on the same day.

D. GUIDELINES FOR HOSPITAL OBSERVATION, HOSPITAL INPATIENT, CONSULTATIONS, EMERGENCY DEPARTMENT, NURSING FACILITY, DOMICILIARY REST HOME, OR CUSTODIAL CARE, AND HOME E/M SERVICES:

- The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are:
 - History;
 - Examination;
 - Medical decision making;
 - Counseling;
 - Coordination of care;
 - Nature of presenting problem;
 - Time.

The first three of these components (history, examination, and medical decision making) are considered the **key** components in selecting a level of E/M services. (See “Determine the Extent of History Obtained.”)

The next three components (counseling, coordination of care, and the nature of the presenting problem) are considered **contributory** factors in the majority of encounters. Although the first two of these contributory factors are important E/M services, it is not required that these services be provided at every patient encounter.

Coordination of care with other physicians, other health care professionals, or agencies without a patient encounter on that day is reported using the case management codes.

The final component, time, is discussed in detail in section C.

- Chief Complaint: A chief complaint is a concise statement describing the symptom, problem, condition, diagnosis, or other factor that is the reason for the encounter, usually stated in the patient's words.
- History of Present Illness: A chronological description of the development of the patient's present illness from the first sign and/or symptom to the present. This includes a description of location, quality, severity, timing, context, modifying factors, and associated signs and symptoms significantly related to the presenting problem(s).
- ~~Levels of E/M Services: Within each category or subcategory of E/M service, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are NOT interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient.~~

~~The levels of E/M services include examinations, evaluations, treatments, conferences with or concerning patients, preventive pediatric and adult health supervision, and similar medical services, such as the determination of the need and/or location for appropriate care. Medical screening includes the history, examination, and medical decision making required to determine the need and/or location for appropriate care and treatment of the patient (e.g., office and other outpatient setting, emergency department, nursing facility). The levels of E/M services encompass the wide variations in skill, effort, time, responsibility and medical knowledge required for the prevention or diagnosis and treatment of illness or injury and the promotion of optimal health. Each level of E/M services may be used by all physicians.~~

~~The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are:~~

- ~~History;~~
- ~~Examination;~~
- ~~Medical decision making;~~
- ~~Counseling;~~
- ~~Coordination of care;~~
- ~~Nature of presenting problem; and~~
- ~~Time.~~

~~The first three of these components (history, examination and medical decision making) are considered the key components in selecting a level of E/M services.~~

~~The next three components (counseling, coordination of care, and the nature of the presenting problem) are considered contributory factors in the majority of encounters. Although the first two of these contributory factors are important E/M services, it is not required that these services be provided at every patient encounter.~~

~~Coordination of care with other physicians, other health care professionals, or agencies without a patient encounter on that day is reported using the case management codes.~~

~~The final component, time, is discussed in the following pages.~~

~~Any specifically identifiable procedure (i.e., identified with a specific CPT[®] code) performed on or subsequent to the date of initial or subsequent E/M services should be reported separately.~~

~~The actual performance and/or interpretation of diagnostic test/studies ordered during a patient encounter are not included in the levels of E/M services. Physician performance of diagnostic tests/studies for which specific CPT[®] codes are available may be reported separately, in addition to the appropriate E/M code. The physician's interpretation of the results of diagnostic tests/studies (i.e., professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT[®] code with modifier 26 appended.~~

~~The physician may need to indicate that on the day a procedure or service identified by a CPT[®] code was performed, the patient's condition required a significant separately identifiable E/M service above and beyond other services provided or beyond the usual preservice and post service care associated with the procedure that was performed. The E/M service may be caused or prompted by the symptoms or condition for which the procedure and/or service was provided. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. As such, different diagnoses are not required for reporting of the procedure and the E/M services on the same date.~~

- **Nature of Presenting Problem:** A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter. The E/M codes recognize five types of presenting problems that are defined as follows:

Minimal - A problem that may not require the presence of the physician, but service is provided under the physician's supervision.

Self-limited or Minor - A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status. ~~OR has a good prognosis with management/compliance.~~

Low severity - A problem where the risk of morbidity without treatment is low; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected.

Moderate severity - A problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment.

High severity - A problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment.

- Past History: A review of the patient's past experiences with illnesses, injuries, and treatments that includes significant information about:
 - Prior major illnesses and injuries;
 - Prior operations;
 - Prior hospitalizations;
 - Current medications;
 - Allergies (e.g., drug, food);
 - Age appropriate immunization status;
 - Age appropriate feeding/dietary status.

- Family History: A review of medical events in the patient's family that includes significant information about:
 - The health status or cause of death of parents, siblings and children;
 - Specific diseases related to problems identified in the Chief Complaint or History of the Present Illness, and/or System Review;
 - Diseases of family members which may be hereditary or place the patient at risk.

- Social History: An age appropriate review of past and current activities that includes significant information about:
 - Marital status and/or living arrangements;
 - Current employment;
 - Occupational history;
 - Military history;
 - Use of drugs, alcohol, and tobacco;
 - Level of education;
 - Sexual history;
 - Other relevant social factors.

- System Review (Review of Systems): An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced. For the purposes of CPT®, the following elements of a system review have been identified:

- Constitutional symptoms (fever, weight loss, etc.);
- Eyes;
- Ears, nose, mouth, throat;
- Cardiovascular;
- Respiratory;
- Gastrointestinal;
- Genitourinary;
- Musculoskeletal;
- Integumentary (skin and/or breast);
- Neurological;
- Psychiatric;
- Endocrine;
- Hematologic/Lymphatic;
- Allergic/Immunologic.

The review of systems helps define the problem, clarify the differential diagnosis, identify needed testing, or serves as baseline data on other systems that might be affected by any possible management options.

- ~~Time: The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions of CPT[®]. The inclusion of time as an explicit factor beginning in CPT[®] 1992 is done to assist in selecting the most appropriate level of E/M services. It should be recognized that the specific times expressed in the visit code descriptors are averages and, therefore, represent a range of times which may be higher or lower depending on actual clinical circumstances.~~

~~Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult to provide accurate estimates of the time spent face to face with the patient.~~

~~Studies to establish levels of E/M services employed surveys of practicing physicians to obtain data on the amount of time and work associated with typical E/M services. Since “work” is not easily quantifiable, the codes must rely on other objective, verifiable measures that correlate with physicians’ estimates of their “work.” It has been demonstrated that estimations of intraservice time (as explained below), both within and across specialties, is a variable that is predictive of the “work” of E/M services. This same research has shown there is a strong relationship between intraservice time and total time for E/M services. Intraservice time, rather than total time, was chosen for inclusion with the codes because of its relative ease of measurement and because of its direct correlation with measurements of the total amount of time and work associated with typical E/M services.~~

~~Intraservice times are defined as **face-to-face** time for office and other outpatient visits and as **unit/floor** time for hospital and other inpatient visits. This distinction is~~

necessary because most of the work of typical office visits takes place during the face-to-face time with the patient, while most of the work of typical hospital visits takes place during the time spent on the patient's floor or unit. When prolonged time occurs in either the office or the inpatient areas, the appropriate add-on code should be reported.

~~Face-to-face time (office and other outpatient visits and office consultations): For coding purposes, face-to-face time for these services is defined as only that time spent face-to-face with the patient and/or family. This includes the time spent performing such tasks as obtaining a history, performing an examination, and counseling the patient.~~

~~Time is also spent doing work before or after the face-to-face time with the patient, performing such tasks as reviewing records and tests, arranging for further services, and communicating further with other professionals and the patient through written reports and telephone contact.~~

~~This non-face-to-face time for office services—also called pre- and post-encounter time—is not included in the time component described in the E/M codes. However, the pre- and post-non-face-to-face work associated with an encounter was included in calculating the total work of typical services in physician surveys.~~

~~Thus, the face-to-face time associated with the services described by any E/M code is a valid proxy for the total work done before, during, and after the visit.~~

~~Unit/floor time (hospital observation services, inpatient hospital care, initial inpatient hospital consultations, nursing facility): For reporting purposes, intraservice time for these services is defined as unit/floor time, which includes the time present on the patient's hospital unit and at the bedside rendering services for that patient. This includes the time to establish and/or review the patient's chart, examine the patient, write notes, and communicate with other professionals and the patient's family.~~

~~In the hospital, pre- and post-time includes time spent off the patient's floor performing such tasks as reviewing pathology and radiology findings in another part of the hospital.~~

~~This pre- and post-visit time is not included in the time component described in these codes. However, the pre- and post-work performed during the time spent off the floor or unit was included in calculating the total work of typical services in physician surveys.~~

~~Thus, the unit/floor time associated with the services described by any code is a valid proxy for the total work done before, during, and after the visit.~~

E. INSTRUCTIONS FOR SELECTING A LEVEL OF E/M SERVICE FOR HOSPITAL OBSERVATION, HOSPITAL INPATIENT, CONSULTATIONS, EMERGENCY

DEPARTMENT, NURSING FACILITY, DOMICILIARY REST HOME, OR CUSTODIAL CARE, AND HOME E/M SERVICES:

- Review the Level of E/M Service Descriptors and Examples in the Selected Category or Subcategory: The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are:

- History;
- Examination;
- Medical decision making;
- Counseling;
- Coordination of care;
- Nature of presenting problem;
- Time.

The first three components (i.e., history, examination, and medical decision making) should be considered the key components in selecting the level of E/M services. An exception to this rule is in the case of visits that consist predominately of counseling or coordination of care.

The nature of the presenting problem and time are provided in some levels to assist the physician in determining the appropriate level of E/M service.

- Determine the Extent of History Obtained: The extent of the history is dependent upon clinical judgment and on the nature of the presenting problem(s). The levels of E/M services recognize four types of history that are defined as follows:

Problem Focused - Chief complaint; brief history of present illness or problem.

Expanded Problem Focused - Chief complaint; brief history of present illness; problem pertinent system review.

Detailed - Chief complaint; extended history of present illness; problem pertinent system review extended to include a review of a limited number of additional systems; pertinent past, family, and/or social history directly related to the patient's problems.

Comprehensive - Chief complaint; extended history of present illness; review of systems that is directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems; complete past, family, and social history.

The comprehensive history obtained as part of the preventive medicine E/M service is not problem-oriented and does not involve a chief complaint or present illness. It does, however, include a comprehensive system review and comprehensive or interval past,

family, and social history as well as a comprehensive assessment/history of pertinent risk factors.

- Determine the Extent of Examination Performed: The extent of the examination performed is dependent on clinical judgment and on the nature of the presenting problem(s). The levels of E/M services recognize four types of examination that are defined as follows:

Problem Focused - A limited examination of the affected body area or organ system.

Expanded Problem Focused - A limited examination of the affected body area or organ system and other symptomatic or related organ system(s).

Detailed - An extended examination of the affected body area(s) and other symptomatic or related organ system(s).

Comprehensive - A general multisystem examination or a complete examination of a single organ system. Note: The comprehensive examination performed as part of the preventive medicine E/M service is multisystem, but its extent is based on age and risk factors identified.

For the purposes of these CPT® definitions, the following body areas are recognized:

- Head, including the face;
- Neck;
- Chest, including breasts and axilla;
- Abdomen;
- Genitalia, groin, buttocks;
- Back;
- Each extremity;

For the purposes of these CPT® definitions, the following organ systems are recognized:

- Eyes;
- Ears, nose, mouth, and throat;
- Cardiovascular;
- Respiratory;
- Gastrointestinal;
- Genitourinary;
- Musculoskeletal;
- Skin;
- Neurologic;
- Psychiatric;
- Hematologic/Lymphatic/Immunologic.

- Determine the Complexity of Medical Decision Making:

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- The number of possible diagnoses and/or the number of management options that must be considered;
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- The risk of significant complications, morbidity, and/or mortality, as well as comorbidities, associated with the patient’s presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

Four types of medical decision making are recognized: straightforward; low complexity; moderate complexity; and high complexity. To qualify for a given type of decision making, two of the three elements in Table 1, Complexity of Medical Decision Making, must be met or exceeded.

Table 1 – Complexity of Medical Decision Making

<u>Number of Diagnoses or Management Options</u>	<u>Amount and/or Complexity of Data to be Reviewed</u>	<u>Risk of Complications and/or Morbidity or Mortality</u>	<u>Type of Decision Making</u>
<u>Minimal</u>	<u>Minimal or none</u>	<u>Minimal</u>	<u>Straightforward</u>
<u>Limited</u>	<u>Limited</u>	<u>Low</u>	<u>Low complexity</u>
<u>Multiple</u>	<u>Moderate</u>	<u>Moderate</u>	<u>Moderate complexity</u>
<u>Extensive</u>	<u>Extensive</u>	<u>High</u>	<u>High complexity</u>

Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless their presence significantly increases the complexity of the medical decision making.

- Select the Appropriate Level of E/M Services Based on the Following:
 1. For the following categories/subcategories, **all of the key components** i.e., history, examination, and medical decision making, must meet or exceed the stated requirements to qualify for a particular level of E/M service: initial observation care; initial hospital care; observation or inpatient hospital care (including admission and discharge services); office or other outpatient consultations, inpatient consultations; emergency department services; initial nursing facility care; other nursing facility services; domiciliary care, new patient; and home

services, new patient.

2. For the following categories/subcategories, **two of the three key components** (i.e., history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M services: subsequent observation care; subsequent hospital care; subsequent nursing facility care; domiciliary care, established patient; and home services, established patient.
3. When counseling and/or coordination of care dominates (more than 50%) the encounter with the patient and/or family (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then **time** shall be considered the key or controlling factor to qualify for a particular level of E/M services. This includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members (e.g., foster parents, person acting in loco parentis, legal guardian). The extent of counseling and/or coordination of care must be documented in the medical record.

F. GUIDELINES FOR OFFICE OR OTHER OUTPATIENT E/M SERVICES:

- History and/or Examination: Office or other outpatient services include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination are determined by the treating physician reporting the service. The care team may collect information and the patient or caregiver may supply information directly (e.g., by electronic health record [EHR] portal or questionnaire) that is reviewed by the reporting physician. The extent of history and physical examination is not an element in the selection of the office or other outpatient codes.
- Number and Complexity of Problems Addressed at the Encounter: One element used in selecting the level of office or other outpatient services is the number and complexity of the problems that are addressed at an encounter. Multiple new or established conditions may be addressed at the same time and may affect MDM. Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services **unless** they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Therefore, presenting symptoms that are unlikely to represent a highly morbid condition may “drive” MDM even when the ultimate diagnosis is not highly morbid. The evaluation and/or treatment should be consistent with the likely nature of the condition. Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

The term “risk” as used in these definitions relates to risk from the condition. While condition risk and management risk may often correlate, the risk from the condition is distinct from the risk of management.

Definitions for the elements of MDM (see Table 2, Levels of Medical Decision Making) for other office or other outpatient services are:

Problem: A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.

Problem addressed: A problem is addressed or managed when it is evaluated or treated at the encounter by the physician reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. Notation in the patient’s medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician reporting the service. Referral without evaluation (by history, examination, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician reporting the service.

Minimal problem: A problem that may not require the presence of the physician, but the service is provided under the physician’s supervision (see 99211).

Self-limiting or minor problem: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.

Stable, chronic illness: A problem with an expected duration of at least one year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (e.g., uncontrolled diabetes and controlled diabetes are a single chronic condition). “Stable” for the purposes of categorizing MDM is defined by the specific treatment goals for an individual patient. A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, in a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic, the risk of morbidity **without** treatment is significant. Examples may include well-controlled hypertension, non-insulin-dependent diabetes, cataract, or benign prostatic hyperplasia.

Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute, uncomplicated illness. Examples may include cystitis, allergic rhinitis, or a simple sprain.

Chronic illness with exacerbation, progression, or side effects of treatment: A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects but that does not require consideration of hospital level of care.

Undiagnosed new problem with uncertain prognosis: A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment. An example may be a lump in the breast.

Acute illness with systemic symptoms: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, shorten the course of illness, or to prevent complications, see the definitions for *self-limited or minor problem* or *acute, uncomplicated illness or injury*. Systemic symptoms may not be general but may be single system. Examples may include pyelonephritis, pneumonitis, or colitis.

Acute, complicated injury: An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with a risk of morbidity. An example may be a head injury with brief loss of consciousness.

Chronic illness with severe exacerbation, progression, or side effects of treatment: The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require hospital level of care.

Acute or chronic illness or injury that poses a threat to life or bodily function: An acute illness with systemic symptoms, and acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. Examples may include myocardial infarction, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure, or an abrupt change in neurologic status.

Analyzed: the process of using the data as part of the MDM. The data element itself may not be subject to analysis (e.g., glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment. Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter. Tests that are ordered outside of an encounter may be counted in the encounter in which they are analyzed. In the case of a recurring order, each new result may be counted in the encounter in which it is analyzed. For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter. Any service for which the professional component is separately reported by the physician reporting the E/M services is not counted as a data element

ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.

Test: Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (e.g., basic metabolic panel [80047]) is a single test. The differentiation between single or multiple tests is defined in accordance with the CPT[®] code set. For the purposes of data reviewed and analyzed, pulse oximetry is not a test.

Unique: A unique test is defined by the CPT[®] code set. When multiple results of the same unique test (e.g., serial blood glucose values) are compared during an E/M service, count it as one unique test. Tests that have overlapping elements are not unique, even if they are identified with distinct CPT[®] codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC, without differential, and platelet count. A unique source is defined as a physician in a distinct group or different specialty or subspecialty, or a unique entity. Review of all the materials from any unique source counts as one element toward MDM.

Combination of Data Elements: A combination of different data elements, for example, a combination of notes reviewed, tests ordered, tests reviewed, or independent historian, allows these elements to be summed. It does not require each item type or category to be represented. A unique test ordered, plus a note reviewed and an independent historian would be a combination of three elements.

External: External records, communications and/or test results are from an external physician, other qualified health care professional, facility, or health care organization.

External physician or other qualified health care professional: An external physician or other qualified health care professional who is not in the same group practice or is of a different specialty or subspecialty. This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational provider such as from a hospital, nursing facility, or home health care agency.

Discussion: Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (e.g., clinical staff or trainees). Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange. The discussion does not need to be on the date of the encounter, but it is counted only once and only when it is used in the decision making of the encounter. It may be synchronous (i.e., does not need to be in person), but it must be initiated and completed within a short time period (e.g., within a day or two).

Independent historian(s): An individual (e.g., parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (e.g., due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement

is met. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.

Independent interpretations: The interpretation of a test for which there is a CPT® code and an interpretation or report is customary. This does not apply when the physician is reporting the service or has previously reported the service for the patient. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

Appropriate source: For the purpose of the discussion of management data element (see Table 2, levels of Medical Decision Making), an appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient (e.g., lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers.

One element used in selecting the level of service is the risk of complications and/or morbidity or mortality of patient management at an encounter. This is distinct from the risk of the condition itself.

Risk: The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician in the same specialty. Trained clinicians apply common language usage meanings to terms such as *high, medium, low, or minimal* risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities). For the purposes of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment and/or hospitalization. The risk of patient management criteria applies to the patient management decisions made by the reporting physician as part of the reported encounter.

Morbidity: A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.

Social determinants of health: Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.

Surgery (minor or major, elective, emergency, procedure or patient risk):

Surgery - Minor or Major: The classification of surgery into minor or major is based on the common meaning of such terms when used by trained clinicians, similar to the use of the term “risk”. These terms are not defined by a surgical package classification.

Surgery – Elective or Emergency: Elective procedures and emergent or urgent procedures describe the timing of the procedure when the timing is related to the patient’s condition. An elective procedure is typically planned in advance (e.g., scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures.

Surgery – Risk Factors, Patient or Procedure: Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.

Drug therapy requiring intensive monitoring for toxicity: A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. The monitoring should be that which is generally accepted practice for the agent but may be patient-specific in some cases. Intensive monitoring may be long-term or short-term. Long-term intensive monitoring is not performed less than quarterly. The monitoring may be performed with a laboratory test, a physiologic test, or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of MDM in an encounter in which it is considered in the management of the patient. Examples may include monitoring for cytopenia in the use of an antineoplastic agent between dose cycles or the short-term intensive monitoring of electrolytes and renal function in a patient who is undergoing diuresis. Examples of monitoring that do not qualify include monitoring glucose levels during insulin therapy, as the primary reason is the therapeutic effect (unless severe hypoglycemia is a current, significant concern); or annual electrolytes and renal function for a patient on a diuretic, as the frequency does not meet the threshold.

G. INSTRUCTIONS FOR SELECTING A LEVEL OF OFFICE OR OTHER OUTPATIENT E/M SERVICES:

- Select the Appropriate Level of E/M Services Based on the Following:
 1. The level of the MDM as defined for each service, or
 2. The total time for E/M services performed on the date of the encounter.
- Medical Decision Making: MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. MDM in the office or other outpatient services codes is defined by three elements:
 - The number and complexity of problem(s) that are addressed during the encounter.
 - The amount and/or complexity of data to be reviewed and analyzed. These data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information

obtained from multiple sources or interprofessional communications that are not reported separately and interpretation of tests that are not reported separately. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter. Ordering a test may include those considered, but not selected after shared decision making. For example, a patient may request diagnostic imaging that is not necessary for their condition and discussion of the lack of benefit may be required. Alternatively, a test may normally be performed, but due to the risk for a specific patient it is not ordered. Data are divided into three categories:

1. Tests, documents, orders or independent historian(s). (Each unique test, order, or document is counted to meet a threshold number.)
 2. Independent interpretation of tests.
 3. Discussion of management or test interpretation with external physician or appropriate source.
- The risk of complications and/or morbidity or mortality of patient management decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s), and/or treatment(s). This includes the possible management options selected and those considered but not selected, after shared MDM with the patient and/or family. For example, a decision about hospitalization includes of alternative levels of care. Examples may include a psychiatric patient with a sufficient degree of support in the outpatient setting or the decision to not hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment.

Four types of MDM are recognized: straightforward, low, moderate, and high. The concept of the level of MDM does not apply to 99211.

Shared MDM involves eliciting patient and/or family preferences, patient and/or family education, and explaining risks and benefits of management options.

MDM may be impacted by role and management responsibility.

When the physician is reporting a separate CPT® code that includes interpretation and/or report, the interpretation and/or report should not count toward the MDM when selecting a level of office or other outpatient services. When the physician is reporting a separate service for discussion of management with a physician, the discussion is not counted toward the MDM when selecting a level of office or other outpatient services.

The Levels of Medical Decision Making (MDM) table (Table 2) is a guide to assist in selecting the level of MDM for reporting an office or other outpatient E/M services code. The table includes the four levels of MDM (i.e., straightforward, low, moderate, high) and the three elements of MDM (i.e., number and complexity of problems addressed at the encounter, amount and/or complexity of data reviewed and analyzed,

and risk of complications and/or morbidity or mortality of patient management). To qualify for a particular level of MDM, two of the three elements for that level of MDM must be met or exceeded. See Table 2: Levels of Medical Decision Making (MDM).

Table 2: Levels of Medical Decision Making (MDM)

Elements of Medical Decision Making				
Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed <i>*Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below</i>	Risk or Complications and/or Morbidity or Mortality of Patient Management
<u>99211</u>	N/A	N/A	N/A	N/A
<u>99202</u> <u>99212</u>	Straightforward	Minimal 1 self-limited or minor problem	Minimal or more	Minimal risk of morbidity from additional diagnostic testing or treatment
<u>99203</u> <u>99213</u>	Low	Low 2 or more self-limited or minor problems; or 1 stable, chronic illness; or 1 acute, uncomplicated illness or injury	Limited <i>(Must meet the requirements of at least 1 out of the 2 categories)</i> Category 1: Tests and documents Any Combination of 2 from the following: Review of prior external note(s) from each unique source*; Review of the result(s) of each unique test*; Ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) <i>(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)</i>	Low risk of morbidity from additional diagnostic testing or treatment
<u>99204</u> <u>99214</u>	Moderate	Moderate 1 or more chronic illnesses with exacerbation, progression, or side effects treatment; or 2 or more stable, chronic illnesses; or	Moderate <i>(Must meet the requirements of at least 1 of the 3 categories)</i> Category 1: Tests, Documents, or independent historian(s) Any combination of 3 from the following: Review of prior external note(s) from each unique source*; Review of the result(s) of each unique test*; Ordering of each unique test*; Assessment requiring an independent historian(s)	Moderate risk of morbidity from additional diagnostic testing or treatment <i>Examples only:</i> Prescription drug management Decision regarding minor surgery with identified patient or procedure risk forms Decision regarding elective major surgery without identified patient or procedure risk factors

		<u>1 undiagnosed new problem with uncertain prognosis;</u> <u>or</u> <u>1 acute illness with systemic symptoms;</u> <u>or</u> <u>1 acute, complicated injury</u>	<u>or</u> <u>Category 2: Independent interpretation of tests</u> <u>Independent interpretation of a test performed by another physician (not separately reported);</u> <u>or</u> <u>Category 3: Discussion of management or test interpretation</u> <u>Discussion of management or test interpretation with external physician/appropriate source (not separately reported)</u>	<u>Diagnosis or treatment significantly limited by social determinants of health</u>
<u>99205</u> <u>99215</u>	<u>High</u>	<u>High</u> <u>1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;</u> <u>or</u> <u>1 acute or chronic illness or injury that poses a threat to life or bodily function</u>	<u>Extensive</u> <u>(Must meet the requirements of at least 2 out of the 3 categories)</u> <u>Category 1: Tests, documents, or independent historian(s)</u> <u>Any combination of 3 from the following:</u> <u>Review of prior external notes(s) from each unique source*;</u> <u>Review of the result(s) of each unique test*;</u> <u>Ordering of each unique test*;</u> <u>Assessment requiring an independent historian(s)</u> <u>or</u> <u>Category 2: Independent interpretation of tests</u> <u>Independent interpretation of a test performed by another physician (not separately reported);</u> <u>or</u> <u>Category 3: Discussion of management or test interpretation</u> <u>Discussion of management or test interpretation with external physician/appropriate source (not separately reported)</u>	<u>High risk of morbidity from additional diagnostic testing or treatment</u> <u>Examples only:</u> <u>Drug therapy requiring intensive monitoring for toxicity</u> <u>Decision regarding elective major surgery with identified patient or procedure risk factors</u> <u>Decision regarding emergency major surgery</u> <u>Decision regarding hospitalization</u> <u>Decision not to resuscitate or to de-escalate care because of poor prognosis</u>

H. TIME: For instructions on using time to select the level of office or other outpatient E/M services code, see the *Time* subsection in Item C (*Guidelines Common to all E/M Services*).

EJ. UNLISTED SERVICE: An E/M service may be provided that is not listed in this section of CPT® codebook. When reporting such a service, the appropriate unlisted code may be used to indicate the service, identifying it by “Special Report,” as discussed in item DJ. The “Unlisted Services” and accompanying codes for the E/M section are as follows:

99429 Unlisted preventive medicine service
99499 Unlisted evaluation and management service

~~DJ~~. SPECIAL REPORT: An unlisted service or one that is unusual, variable, or new may require a special report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure and the time, effort, and equipment necessary to provide the service. Additional items that may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care.

~~EK~~. CLINICAL EXAMPLES: Clinical examples of the codes for E/M services are provided to assist in understanding the meaning of the descriptors and selecting the correct code. The clinical examples are listed in Appendix C. (*Appendix C of the CPT® has not been reprinted in this text.*) Each example was developed by the specialties shown.

The same problem, when seen by different specialties, may involve different amounts of work. Therefore, the appropriate level of encounter should be reported using the descriptors rather than the examples.

~~— INSTRUCTIONS FOR SELECTING A LEVEL OF E/M SERVICE:~~

~~Review the Reporting Instructions for the Selected Category or Subcategory: Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, e.g., “Inpatient Hospital Care,” special instructions will be presented preceding the levels of E/M services.~~

~~Review the Level of E/M Service Descriptors and Examples in the Selected Category or Subcategory: The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are:~~

- ~~• History;~~
- ~~• Examination;~~
- ~~• Medical decision making;~~
- ~~• Counseling;~~
- ~~• Coordination of care;~~
- ~~• Nature of presenting problem;~~
- ~~• Time.~~

~~The first three of these components (i.e., history, examination and medical decision making) should be considered the key components in selecting the level of E/M services. An exception to this rule is in the case of visits which consist predominantly of counseling or coordination of care. (See instructions for selecting level of E/M Service).~~

~~The nature of the presenting problem and time are provided in some levels to assist the physician in determining the appropriate level of E/M service.~~

~~Determine the Extent of History Obtained: The extent of the history is dependent upon clinical judgment and on the nature of the presenting problem(s). The levels of E/M services recognize four types of history that are defined as follows:~~

~~Problem Focused—Chief complaint; brief history of present illness or problem.~~

~~Expanded Problem Focused—Chief complaint; brief history of present illness; problem pertinent system review.~~

~~Detailed—Chief complaint; extended history of present illness; problem pertinent system review extended to include a review of a limited number of additional systems; pertinent past, family, and/or social history directly related to the patient's problems.~~

~~Comprehensive—Chief complaint; extended history of present illness; review of systems that is directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems; complete past, family, and social history.~~

~~The comprehensive history obtained as part of the preventive medicine E/M service is not problem-oriented and does not involve a chief complaint or present illness. It does, however, include a comprehensive system review and comprehensive or interval past, family, and social history as well as a comprehensive assessment/history of pertinent risk factors.~~

- ~~• Determine the Extent of Examination Performed: The extent of the examination performed is dependent on clinical judgment and on the nature of the presenting problem(s). The levels of E/M services recognize four types of examination that are defined as follows:~~

~~Problem Focused—A limited examination of the affected body area or organ system.~~

~~Expanded Problem Focused—A limited examination of the affected body area or organ system and other symptomatic or related organ system(s).~~

~~Detailed—An extended examination of the affected body area(s) and other symptomatic or related organ system(s).~~

~~Comprehensive—A general multisystem examination or a complete examination of a single organ system. Note: The comprehensive examination performed as part of the preventive medicine E/M service is multisystem, but its extent is based on age and risk factors identified.~~

~~———— For the purposes of these CPT[®] definitions, the following body areas are recognized:~~

- ~~• Head, including the face; —~~
- ~~• Neck;~~
- ~~• Chest, including breasts and axilla;~~

- Abdomen;
- Genitalia, groin, buttocks;
- Back;
- Each extremity;

~~For the purposes of these CPT® definitions, the following organ systems are recognized:~~

- Eyes;
- Ears, nose, mouth, and throat;
- Cardiovascular;
- Respiratory;
- Gastrointestinal;
- Genitourinary;
- Musculoskeletal;
- Skin;
- Neurologic;
- Psychiatric;
- Hematologic/Lymphatic/Immunologic.

- ~~Determine the Complexity of Medical Decision Making: Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:~~

- ~~The number of possible diagnoses and/or the number of management options that must be considered;~~
- ~~The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and~~
- ~~The risk of significant complications, morbidity, and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.~~

~~Four types of medical decision making are recognized: straightforward; low complexity; moderate complexity; and high complexity. To qualify for a given type of decision making, two of the three elements in the table following must be met or exceeded.~~

Table 1—Complexity of Medical Decision Making

Number of Diagnoses or Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Complications and/or Morbidity or Mortality	Type of Decision Making
Minimal	Minimal or none	Minimal	Straightforward
Limited	Limited	Low	Low complexity

Multiple	Moderate	Moderate	Moderate complexity
Extensive	Extensive	High	High complexity

~~Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless their presence significantly increases the complexity of the medical decision-making.~~

Select the Appropriate Level of E/M Services Based on the Following:

1. ~~For the following categories/subcategories, **all of the key components** i.e., history, examination, and medical decision making, must meet or exceed the stated requirements to qualify for a particular level of E/M service: office, new patient; hospital observation services; initial hospital care; office consultations; initial inpatient consultations; emergency department services; initial nursing facility care; domiciliary care, new patient; and home, new patient.~~

2. ~~For the following categories/subcategories, **two of the three key components** (i.e., history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M services: office, established patient; subsequent hospital care; subsequent nursing facility care; domiciliary care, established patient; and home, established patient.~~

~~When counseling and/or coordination of care dominates (more than 50%) the encounter with the patient and/or family (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then **time** shall be considered the key or controlling factor to qualify for a particular level of E/M services. This includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members (e.g., foster parents, person acting in loco parentis, legal guardian). The extent of counseling and/or coordination of care must be documented in the medical record.~~

